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CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Repeal of Current Rules 3080-3350 Governing Coordinated Care Organizations (CCOs)

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RULES:
410-141-3080, 410-141-3110, 410-141-3120, 410-141-3140, 410-141-3145, 410-141-3150, 410-141-3160, 410-141-3170, 410-141-3180, 410-141-3200, 410-141-3220, 410-141-3225, 410-141-3230, 410-141-3235, 410-141-3240, 410-141-3245, 410-141-3246, 410-141-3247, 410-141-3248, 410-141-3250, 410-141-3255, 410-141-3258, 410-141-3259, 410-141-3267, 410-141-3268, 410-141-3269, 410-141-3270, 410-141-3280, 410-141-3300, 410-141-3320, 410-141-3340, 410-141-3345, 410-141-3350

REPEAL: 410-141-3080

RULE TITLE: Disenrollment from Coordinated Care Organizations

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:
(1) Continuity of care for the purpose of this rule means the ability to sustain services necessary for a person's treatment. Continuity of care is a concern when a member is transferred from one service provider to another.
(2) All member-initiated requests for disenrollment from a Coordinated Care Organization (CCO) shall be initiated orally or in writing by the primary person in the benefit group enrolled with a CCO where primary person and benefit group are defined in OAR 461-001-0000, 461-001-0035, and 461-110-0750, respectively. For members who are not able to request disenrollment on their own, the request may be initiated by the member's representative.
(3) In accordance with 42 CFR 438.56(c)(2), the Authority or CCO shall honor a member or representative request for disenrollment for the following:
(a) Without cause (applies to MAGI and non-Medicare APD members as defined by the Office of Client and Community Services Medical Programs OAR 410-200-et al):
(A) Members may request to change their CCO enrollment within 30 days of the Authority's automatic or manual enrollment error. If approved, the change would occur during the next weekly enrollment cycle;

(B) Members may request to change their CCO enrollment within 90 days of the initial CCO enrollment. If approved, the change would occur during the next weekly enrollment cycle;
(C) Members may request to change their CCO enrollment after they have been enrolled with a plan for at least six months. If approved, the change would occur at the end of the month;
(D) Members may request to change their CCO enrollment during OHP eligibility renewal, as defined in OAR 410-141-3060. The OHP eligibility period is typically 12 months. If approved, the change would occur at the end of the month;
(E) Members have one additional opportunity to request a plan change during the eligibility period if none of the above options can be applied. The plan change shall be considered "recipient choice." If approved, the change would occur at the end of the month. Once the recipient choice option has been applied, the member must be enrolled with the same plan at least six months or until the OHP eligibility renewal, whichever comes first, to request an additional plan change.
(b) With cause:
(A) At any time;
(B) Due to moral or religious objections, the CCO does not cover the service the member seeks;
(C) When the member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network, and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk; or
(D) Other reasons including, but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to participating providers who are experienced in dealing with the member's health care needs. Examples of sufficient cause include but are not limited to:
(i) The member moves out of the CCO service area;
(ii) The member is a Native American or Alaskan Native with Proof of Indian Heritage who wishes to obtain primary care services from his or her Indian Health Service facility, tribal health clinic/program, or urban clinic and the Fee-For-Service (FFS) delivery system;
(iii) Continuity of care that is not in conflict with any section of OAR 410-141-3060, or as defined in this rule. Participation in OHP, including coordinated care or dental care, does not guarantee that any OHP member has a right to continued care or treatment by a specific provider. A request for disenrollment based on continuity of care shall be denied if the basis for this request is primarily for the convenience of an OHP member or a provider of a treatment, service, or supply, including but not limited to a decision of a provider to participate or decline to participate in a CCO;
(iv) As specified in ORS 414.647, the Authority may approve the transfer of 500 or more members from one CCO to another CCO if:
(I) The member's provider has contracted with the receiving CCO and has stopped accepting patients from or has terminated providing services to members in the transferring CCO; and
(II) Members are offered the choice of remaining enrolled in the transferring CCO; and
(III) The member and all family (case) members shall be transferred to the provider's new CCO; and
(IV) The transfer shall take effect when the provider's contract with their current CCO contractual relationship ends, or on a date approved by the Division; and
(V) Members may not be transferred under section (2)(E)(vi) until the Division has evaluated the receiving CCO and determined that the CCO meets criteria established by the Division as stated in rule including, but not limited to, ensuring that the CCO maintains a network of providers sufficient in numbers, areas of practice, and geographically distributed in a manner to ensure that the health services provided under the contract are reasonably accessible to members; and
(VI) The Division shall provide notice of a transfer to members affected by the transfer at least 90 days before the scheduled date of the transfer.
(E) If a member's disenrollment is denied, notice of denial shall be sent to the member pursuant to OAR 410-141-3230 and 410-141-3235 of their right to file a grievance or request a hearing.
(c) If the following conditions are met:
(A) As supported in 42 CFR 438.56(d)(2), if a member is at any point in the third trimester of pregnancy and if the

member is newly determined eligible for OHP, or the member is newly re-determined eligible for OHP and not enrolled in a CCO within the past three months; or
(B) If the member is enrolled with a new CCO that does not contract with the member's current OB provider and the member wishes to continue obtaining maternity services from that non-participating OB provider;
(C) The enrollment exemption shall remain in place until 60 days postdate of delivery of the member's child, at which time the member shall select and be enrolled in the appropriate CCO plan in their service area.
(d) For purposes of a member's right to file a grievance or request a hearing, disenrollment does not include the following:
(A) Transfer of a member from a PHP to a CCO;
(B) Involuntary transfer of a member from a CCO to another CCO; or
(C) Automatic enrollment of a member in a CCO.
(e) Member disenrollment requests are subject to the following requirements:
(A) The member shall join another CCO unless the member resides in a service area where enrollment is voluntary, or the member meets the exemptions to enrollment set forth in OAR 410-141-3060 or 410-141-0060, or the member meets disenrollment criteria stated in 42 CFR 438.56(c)(2), or there is not another CCO in the service area;
(B) The effective date of disenrollment shall be the end of the month in which disenrollment was requested unless the Division approves retroactively;
(C) If the Authority fails to make a disenrollment determination by the first day of the second month following the month in which the member files a request for disenrollment, the disenrollment is considered approved.
(4) The CCO may not disenroll members solely for the following reasons:
(a) Because of a physical, intellectual, developmental, or mental disability;
(b) Because of an adverse change in the member's health;
(c) Because of the member's utilization of services, either excessive or lack thereof;
(d) Because the member requests a hearing;
(e) Because the member exercises their option to make decisions regarding their medical care with which the CCO disagrees;
(f) Because of uncooperative or disruptive behavior resulting from the member's special needs.
(5) Subject to applicable disability discrimination laws, the Division may disenroll members for cause when the CCO requests it for cause, which includes but is not limited to the following:
(a) The member commits fraudulent or illegal acts related to the member's participation in the OHP such as: Permitting the use of their medical ID card by others, altering a prescription, theft, or other criminal acts. The CCO shall report any illegal acts to law enforcement authorities and, if appropriate, to DHS Fraud Investigations Unit at 888-Fraud01 (888-372-8301) or http://www.oregon.gov/DHS/abuse/pages/fraud-reporting.aspx as appropriate, consistent with 42 CFR 455.13;
(b) The member became eligible through a hospital hold process and placed in the Adults and Couples category as required under OAR 410-141-3060;
(c) Requests by the CCO for routine disenrollment of specific members shall include the following procedures to be followed and documented prior to requesting disenrollment of a member:
(A) A request shall be submitted in writing to the Coordinated Account Representative (CAR). The CCO shall document the reasons for the request, provide written evidence to support the basis for the request, and document that attempts at intervention were made as described below. The procedures cited below shall be followed and documented prior to requesting disenrollment of a member;
(B) There shall be notification from the provider to the CCO at the time the problem is identified. The notification shall describe the problem and allow time for appropriate resolution by the CCO. Such notification shall be documented in the member's clinical record. The CCO shall conduct provider education or training regarding the need for early intervention, disability accommodation, and the services available to the provider;
(C) The CCO shall contact the member either verbally or in writing, if it is a severe problem, to inform the member of the

problem that has been identified and attempt to develop an agreement with the member regarding the issue. Any contact with the member shall be documented in the member's clinical record. The CCO shall inform the member that their continued behavior may result in disenrollment from the CCO;
(D) The CCO shall provide individual education, disability accommodation, counseling, or other interventions with the member in a serious effort to resolve the problem;
(E) The CCO shall contact the member's care team regarding the problem and, if needed and with the agreement of the member, involve the care team and other appropriate individuals working with the member in the resolution within the laws governing confidentiality;
(F) If the severity of the problem warrants, the CCO shall develop a care plan that details how the problem is going to be addressed and coordinate a care conference with the member, their care team, and other individuals chosen by the member. If necessary, the CCO shall obtain an authorization for release of information from the member for the providers and agencies in order to involve them in the resolution of the problem. If the release is verbal, it shall be documented in the member's record;
(G) The CCO shall submit any additional information or assessments requested by the Division CAR;
(H) The Authority shall notify the member in writing of a disenrollment made as defined in the section above;
(I) If the member's behavior is uncooperative or disruptive, including but not limited to threats or acts of physical violence as the result of his or her special needs or disability, the CCO shall also document each of the following:
(i) A written description of the relationship of the behavior to the special needs or disability of the individual and whether the individual's behavior poses a direct threat to the health or safety of others. Direct threat means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures. In determining whether a member poses a direct threat to the health or safety of others, the CCO shall make an individualized assessment based on reasonable judgment that relies on current medical knowledge or best available objective evidence to ascertain the nature, duration, and severity of the risk to the health or safety of others; the probability that potential injury to others shall actually occur; and whether reasonable modifications of policies, practices, or procedures shall mitigate the risk to others;
(ii) A CCO-staffed interdisciplinary team review that includes a mental health professional or behavioral specialist and other health care professionals who have the appropriate clinical expertise in treating the member's condition to assess the behavior, the behavioral history, and previous history of efforts to manage behavior;
(iii) If warranted, a clinical assessment of whether the behavior will respond to reasonable clinical or social interventions;
(iv) Documentation of any accommodations that have been attempted and why the accommodations haven't worked;
(v) Documentation of the CCO's rationale for concluding that the member's continued enrollment in the CCO seriously impairs the CCO's ability to furnish services to either this particular member or other members;
(vi) If a Primary Care Provider (PCP) terminates the provider/patient relationship, the CCO shall attempt to locate another PCP on their panel who shall accept the member as their patient. If needed, the CCO shall obtain an authorization for release of information from the member in order to share the information necessary for a new provider to evaluate whether they can treat the member. All terminations of provider/patient relationships shall be according to the CCO's policies and shall be consistent with CCO or PCP's policies for commercial members and with applicable disability discrimination laws. The CCO shall determine whether the PCP's termination of the provider/patient relationship is based on behavior related to the member's disability and shall provide education to the PCP about disability discrimination laws.
(d) In addition to the requirements in subsection (c), requests by the CCO for an exception to the routine disenrollment process shall include the following:
(A) In accordance with 42 CFR 438.56, the CCO shall submit a request in writing to the CAR for approval. An exception to the disenrollment process may only be requested for members who have committed an act of or made a credible threat of physical violence directed at a health care provider, the provider's staff, other patients, or the CCO's staff so that it seriously impairs the CCO's ability to furnish services to either this particular member or other members. A

credible threat means that there is a significant risk that the member may cause grievous physical injury to others (including but not limited to death) in the near future, and that risk cannot be eliminated by a modification of policies, practices, or procedures. The CCO shall document the reasons for the request and provide written evidence to support the basis for the request prior to requesting an exception to the disenrollment process of a member;
(B) Providers shall immediately notify the CCO about the incident with the member. The notification shall describe the problem and be maintained for documentation purposes;
(C) The CCO shall attempt and document contact with the member and their care team regarding the problem and, if needed, involve the care team and other appropriate individuals in the resolution within the laws governing confidentiality;
(D) The CCO shall provide any additional information requested by the CAR, the Authority, or the Department assessment team;
(E) If the member's behavior could reasonably be perceived as the result of their special needs or disability, the CCO shall also document each of the following:
(i) A written description of the relationship between the behavior to the special needs or disability of the individual and whether the individual's behavior poses a credible threat of physical violence as defined in section (5)(c)(I)(i) of this rule;
(ii) In determining whether a member poses a credible threat to the health or safety of others, the CCO shall make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or best available objective evidence to ascertain the nature, duration, and severity of the risk to the health or safety of others; the probability that potential injury to others may actually occur; and whether reasonable modifications of policies, practices, or procedures may mitigate the risk to others.
(F) Documentation shall exist that verifies the provider or CCO immediately reported the incident to law enforcement. The CCO shall submit a copy of the police report or case number. If a report is not available, submit a signed entry in the member's clinical record documenting the report to law enforcement or other reasonable evidence;
(G) Documentation shall exist that verifies what reasonable modifications were considered and why reasonable modifications of policies, practices, or procedures may not mitigate the risk to others;
(H) Documentation shall exist that verifies any past incidents and attempts to accommodate similar problems with this member;
(I) Documentation shall exist that verifies the CCO's rationale for concluding that the member's continued enrollment in the CCO seriously impairs the CCO's ability to furnish services to either this particular member or other members.
(e) Approval or denial of disenrollment requests shall include the following:
(A) If there is sufficient documentation, the request shall be evaluated by the CCO's CAR or a team of CARs who may request additional information from Ombudsman Services, the Division, or other agencies as needed. If the request involves the member's mental health condition or behaviors related to substance abuse, the CAR shall also confer with the Division's substance use disorder specialist;
(B) In cases where the member is also enrolled in the CCO's Medicare Advantage plan, the CCO shall provide proof to the Division of CMS' approval to disenroll the member. If approved by the Division, the date of disenrollment from both plans shall be the disenrollment date approved by CMS;
(C) If there is insufficient documentation, the CAR shall notify the CCO within two business days of initial receipt what supporting documentation is needed for final consideration of the request;
(D) The CARs shall review the request and notify the CCO of the decision within ten working days of receipt of sufficient documentation from the CCO;
(E) Written decisions shall be sent to the CCO within 15 working days from receipt of request and sufficient documentation from the CAR.
(6) The following procedures apply to all denied disenrollment requests:
(a) The CAR shall send the member a notice within five days after the decision for denial with a copy to the CCO and the member's care team;
(b) The notice shall give the disenrollment date, the reason for disenrollment, and the notice of the member's right to file

a complaint, as specified in 410-141-3230 through 410-141-3248, and to request an administrative hearing and the option to continue enrollment in the PHP pending the outcome of the hearing in accordance with 42 CFR 438.420. If the member requests a hearing, the disenrollment shall proceed unless the member requests continued enrollment pending a decision;
(c) If disenrollment is approved, the CAR shall contact the member's care team to arrange enrollment in a different plan. The Division may require the member to obtain services from FFS providers until such time as they can be enrolled with another CCO;
(d) If no other CCO is available to the member, the member shall be exempt from enrollment in that type of managed care plan for 12 months. If a member who has been disenrolled for cause is re-enrolled in the CCO, the CCO may request a disenrollment review by the CAR. A member may not be involuntarily disenrolled from the same CCO for a period of more than 12 months. If the member is re-enrolled after the 12-month period and the CCO again requests disenrollment for cause, the request shall be referred to the Authority assessment team for review.
(7) The following procedures apply to all approved disenrollment requests:
(a) The CAR shall send the member a notice within five days after the request was approved with a copy to the CCO and the member's care team;
(b) The notice shall give the disenrollment date, the reason for disenrollment, and the notice of the member's right to file a complaint as specified in OAR 410-141-3230 through 410-141-3248 and to request an administrative hearing and the option to continue enrollment in the CCO pending the outcome of the hearing in accordance with 42 CFR 438.420. If the member requests a hearing, the disenrollment shall proceed unless the member requests continued enrollment pending a decision;
(c) The disenrollment effective date shall be ten calendar days after the disenrollment notice is sent to the member, unless the member requests a hearing and ongoing enrollment pending a hearing decision. The disenrollment shall become effective immediately upon the issuing of an administrative law judge's decision to uphold disenrollment;
(d) If disenrollment is approved, the CAR shall contact the member's care team to arrange enrollment in a different plan. The Division may require the member to obtain services from FFS providers until such time as they can be enrolled with another CCO;
(e) If no other CCO is available to the member, the member shall be exempt from enrollment in that type of managed care plan for 12 months. If a member who has been disenrolled for cause is re-enrolled in the CCO, the CCO may request a disenrollment review by the CAR. A member may not be involuntarily disenrolled from the same CCO for a period of more than 12 months. If the member is re-enrolled after the 12-month period and the CCO or the member again requests disenrollment for cause, the request shall be referred to the Authority's assessment team for review.
(8) Other reasons for the CCO's requests for disenrollment may include the following:
(a) If the member is enrolled in the CCO on the same day the member is admitted to the hospital, the CCO shall be responsible for the hospitalization and the 20-day post-hospital extended care (PHEC) benefit when appropriate. If the member is enrolled after the first day of the inpatient stay, the member shall be disenrolled and enrolled on the next available enrollment date following discharge from inpatient hospital services;
(b) The member has surgery scheduled at the time their enrollment is effective with the CCO, the provider is not on the CCO's provider panel, and the member wishes to have the services performed by that provider;
(c) The Medicare member is enrolled in a Medicare Advantage plan and was receiving hospice services at the time of enrollment in the CCO;
(d) If the CCO determines the member has Third Party Liability (TPL), the CCO shall report the TPL to the Health Insurance Group (HIG) at www.reporttpl.org and HIG send the CCO an email receipt, including a tracking number. The CCO may use this number, should they choose to follow up on their referral submission via the provider portal. If the member is determined to have active TPL, HIG shall disenroll the member from the CCO A or B, effective the end of the month the TPL is reported, as referenced above, and the member is not reflected on that month's 834 report;
(e) If a CCO has knowledge of a member's change of address, the CCO shall notify the member's care team. The care team shall verify the address information and disenroll the member from the CCO if the member no longer resides in

the CCO's service area. Members shall be disenrolled if out of the CCO's service area for more than three months unless previously arranged with the CCO or DCO. The effective date of disenrollment shall be the date specified by the Division, and if a partial month remains, the Division shall recoup the balance of that month's capitation payment from the CCO;

(f) The member is an inmate who is serving time for a criminal offense or confined involuntarily in a state or federal prison, jail, detention facility, or other penal institution. This does not include members on probation, house arrest, living voluntarily in a facility after their case has been adjudicated, infants living with an inmate, or inmates who become inpatients. The CCO shall identify the members and provide sufficient proof of incarceration to the Division for review of the disenrollment request. The Division shall approve requests for disenrollment from CCO's for members who have been taken into custody;

(g) The member is in a state psychiatric institution.

(9) The Division may initiate and disenroll members as follows:

(a) If informed that a member has TPL, the Division shall refer the case to the HIG for investigation and possible exemption from CCO enrollment. The Division shall disenroll members who have TPL effective the end of the month in which HIG makes such a determination. In some situations, the Division may approve retroactive disenrollment;

(b) If the member moves out of the CCO's service area, the effective date of disenrollment shall be the date specified by the Division, and the Division shall recoup the balance of that month's capitation payment from the CCO;

(c) If the member is no longer eligible for OHP, the effective date of disenrollment shall be the date specified by the Division;

(d) If the member dies, the last date of enrollment shall be the date of death.

(10) Unless specified otherwise in these rules or in the Division notification of disenrollment to the CCO, all disenrollments are effective the end of the month the Authority approves the disenrollment with the following exceptions:

(a) The Authority may retroactively disenroll or suspend enrollment when the member is taken into custody. The effective date shall be the date the member was incarcerated;

(b) The Authority may retroactively disenroll the member if they have TPL pursuant to this rule. The effective date shall be the end of the month in which HIG makes the determination.

STATUTORY/OTHER AUTHORITY: ORS 413.032, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3110

RULE TITLE: CCO Substance Use Disorder Provider, Treatment and Facility Certification and Licensure

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) Certain Behavioral Health services are only covered for payment when provided by a Mental Health Organization (MHO), Community Mental Health Program (CMHP), or authorized Coordinated Care Organization (CCO).

(2) Substance Use Disorder (SUD) treatment services are covered for eligible OHP clients when provided by a CCO:

(a) Outpatient substance use disorder providers that are facilities or agencies shall have a certificate issued by the Authority as described in OAR 415-012-0000 for the scope of services provided;

(b) Any facility that meets the definition of a residential treatment facility for substance-dependent persons under ORS 430.010 and 443.400 or detoxification center as defined in ORS 430.306 shall be licensed by the Authority as described in OAR 415-012-0000 for the scope of service provided;

(c) Synthetic opioid treatment programs shall meet the requirements described in OAR 415-020-0000;

(d) Detoxification centers shall have a license issued by the Authority as described in OAR 415-012-0000 and 415-050-0000 for the scope provided.

STATUTORY/OTHER AUTHORITY: ORS 192.527, 192.528, 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 192.527, 192.528, 413.042, 414010, 414.065, 414.727

REPEAL: 410-141-3120

RULE TITLE: Operations and Provision of Health Services

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) CCOs shall establish, maintain, and operate with a governance structure and community advisory council that is consistent with the requirements of ORS 414.625 and applicable health system transformation laws.

(2) At a minimum, CCOs shall provide medically appropriate health services including other health related services within the scope of the member's benefit package of health services in accordance with the Prioritized List of Health Services and the terms of the contract.

(3) CCOs shall select providers using universal application and credentialing procedures and objective quality information. CCOs shall take steps to remove providers from their provider network if they fail to meet objective quality standards:

(a) CCOs shall ensure that all participating providers providing coordinated care services to members are credentialed upon initial contract with the CCO and re-credentialed no less frequently than every three years. The credentialing and re-credentialing process shall include review of any information in the National Practitioners Databank. Pursuant to OAR 409-045-0025 through 409-045-0135, CCOs shall participate in the Oregon Common Credentialing Program to obtain verified credentialing information for health care practitioners.

(b) CCOs shall direct health care practitioners that must be credentialed to the Oregon Common Credentialing Program's electronic system to submit and maintain their credentialing information.

(c) CCOs shall screen their providers to be in compliance with 42 CFR 455 Subpart E (42 CFR 455.410 through 42 CFR 455.470) and retain all resulting documentation for audit purposes;

(d) CCOs may elect to contract for or to delegate responsibility for the credentialing and screening processes; however, CCOs shall be solely and ultimately responsible for adhering with all terms and conditions held in its contract with the state. For the following activities including oversight of the following processes regardless of whether the activities are provided directly, contracted, or delegated, CCOs shall:

(A) Ensure that coordinated care services are provided within the scope of license or certification of the participating provider or facility and within the scope of the participating provider's contracted services. They shall ensure participating providers are appropriately supervised according to their scope of practice;

(B) Provide training for CCO staff and participating providers and their staff regarding the delivery of coordinated care services, applicable administrative rules, and the CCOs administrative policies.

(e) Each contract or written arrangement must specify that:

(A) If any of the CCO activities or obligations under its contract with the state are delegated to a subcontractor:

(i) The delegated activities or obligations and related reporting responsibilities are specified in the contract or written agreement;

(ii) The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the CCO's contract obligations;

(iii) Contracted or written arrangements must either provide for revocation of the delegation of activities or obligations or specify other remedies in instances where the state or the CCO determine that the subcontractor has not performed satisfactorily.

(B) The subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions.

(f) The CCO shall provide accurate and timely information to the Authority about:

(A) License or certification expiration and renewal dates;
(B) Whether a provider's license or certification is expired or not renewed or is subject to licensing termination, suspension, or certification sanction;
(C) If a CCO knows or has reason to know that a provider has been convicted of a felony or misdemeanor related to a crime or violation of federal or state laws under Medicare, Medicaid, or Title XIX (including a plea of "nolo contendre").
(g) CCOs may not refer members to or use providers that:
(A) Have been terminated from the Division;
(B) Have been excluded as a Medicaid provider by another state;
(C) Have been excluded as Medicare/Medicaid providers by CMS; or
(D) Are subject to exclusion for any lawful conviction by a court for which the provider could be excluded under 42 CFR 1001.101.
(h) CCOs may not accept billings for services to members provided after the date of the provider's exclusion, conviction, or termination. CCOs shall recoup any monies paid for services to members provided after the date of the provider's exclusion, conviction, or termination;
(i) CCOs shall require each atypical provider to be enrolled with the Authority and shall obtain and use registered National Provider Identifiers (NPIs) and taxonomy codes reported to the Authority in the Provider Capacity Report for purposes of encounter data submission prior to submitting encounter data in connection with services by the provider. CCOs shall require each qualified provider to have and use an NPI as enumerated by the National Plan and Provider Enumeration System (NPPES);
(j) The provider enrollment request (for encounter purposes) and credentialing documents require the disclosure of taxpayer identification numbers. The Authority shall use taxpayer identification numbers for the administration of this program including provider enrollment, internal verification, and administrative purposes for the medical assistance program for administration of tax laws. The Authority may use taxpayer identification numbers to confirm whether the individual or entity is subject to exclusion from participation in the medical assistance program. Taxpayer identification number includes Employer Identification Number (EIN), Social Security Number (SSN), and Individual Tax Identification Number (ITIN) used to identify the individual or entity on the enrollment request form or disclosure statement. Disclosure of all tax identification numbers for these purposes is mandatory. Failure to submit the requested taxpayer identification numbers may result in denial of enrollment as a provider and denial of a provider number for encounter purposes or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider for encounters.
(4) A CCO may not discriminate with respect to participation in the CCO against any health care provider who is acting within the scope of the provider's license or certification under applicable state law on the basis of that license or certification. If a CCO declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision. This rule may not be construed to:
(a) Require that a CCO contract with any health care provider willing to abide by the terms and conditions for participation established by the CCO; or
(b) Preclude the CCO from establishing varying reimbursement rates based on quality or performance measures. For purposes of this section, quality and performance measures include all factors that advance the goals of health system transformation including:
(A) Factors designed to maintain quality of services and control costs and are consistent with its responsibilities to members; or
(B) Factors that add value to the service provided including but not limited to expertise, experience, accessibility, or cultural competence.
(c) The requirements in subsection (b) do not apply to reimbursement rate variations between providers with the same license or certification or between specialists and non-specialty providers.
(5) A CCO shall establish an internal review process for a provider aggrieved by a decision under section (4) of this rule including an alternative dispute resolution or peer review process. An aggrieved provider may appeal the determination

of the internal review to the Authority.
(6) To resolve appeals made to the Authority under sections (4) and (5) of this rule, the Authority shall provide administrative review of the provider's appeal using the administrative review process established in OAR 410-120-1580. The Authority shall invite the aggrieved provider and the CCO to participate in the administrative review. In making a determination of whether there has been discrimination, the Authority shall consider the CCO's:
(a) Network adequacy;
(b) Provider types and qualifications;
(c) Provider disciplines; and
(d) Provider reimbursement rates.
(7) A prevailing party in an appeal under sections (4) through (6) of this rule shall be awarded the costs of the appeal.

STATUTORY/OTHER AUTHORITY: 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: 414.610 - 414.685

REPEAL: 410-141-3140

RULE TITLE: Emergency and Urgent Care Services

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) CCOs shall have written policies, procedures, and monitoring systems that ensure the provision of appropriate urgent, emergency, and triage services 24-hours a day, 7-days-a-week for all members. CCOs shall:

(a) Communicate these policies and procedures to participating providers;

(b) Regularly monitor participating providers' compliance with these policies and procedures; and

(c) Take any corrective action necessary to ensure compliance. CCOs shall document all monitoring and corrective action activities.

(2) CCOs shall have written policies, procedures, and monitoring processes to ensure that a provider provides a medically or dentally appropriate response as indicated to urgent or emergency calls including but limited to the following:

(a) Telephone or face-to-face evaluation of the member;

(b) Capacity to conduct the elements of an assessment to determine the necessary interventions to begin stabilization;

(c) Development of a course of action;

(d) Provision of services and referral needed to begin post-stabilization care or provide outreach services in the case of a member requiring behavioral health services, or a member who cannot be transported or is homebound;

(e) Provision for notifying a referral emergency room, when applicable, concerning the arriving member's presenting problem, and whether or not the provider will meet the member at the emergency room; and

(f) Provision for notifying other providers, when necessary, to request approval to treat members.

(3) CCOs shall ensure the availability of an after-hours call-in system adequate to triage urgent care and emergency calls from members or a member's long-term care provider or facility. The CCO representative shall return urgent calls appropriate to the member's condition but in no event more than 30 minutes after receipt. If information is not adequate to determine if the call is urgent, the CCO representative shall return the call within 60 minutes to fully assess the nature of the call. If information is adequate to determine that the call may be emergent in nature, the CCO shall return the call.

(4) If emergency room screening examination leads to a clinical determination by the examining provider that an actual emergency medical condition exists under the prudent layperson standard, the CCO must pay for all services required to stabilize the patient, except as otherwise provided in section (6) of this rule. The CCO may not require prior authorization for emergency services:

(a) The CCO may not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergent;

(b) The CCO may not limit what constitutes an emergency medical condition based on lists of diagnoses or symptoms;

(c) The CCO may not deny a claim for emergency services merely because the PCP was not notified, or because the CCO was not billed within ten calendar days of the service.

(5) When a member's PCP, designated provider, or other CCO representative instructs the member to seek emergency care, in or out of the network, the CCO shall pay for the screening examination and other medically appropriate services. Except as otherwise provided in section (6) of this rule, the CCO shall pay for post-stabilization care that was:

(a) Pre-authorized by the CCO;

(b) Not pre-authorized by the CCO if the CCO, or the on-call provider, failed to respond to a request for pre-authorization within one hour of the request, or the member could not contact the CCO or provider on call; or

(c) If the CCO and the treating provider cannot reach an agreement concerning the member's care and a CCO representative is not available for consultation, the CCO must give the treating provider the opportunity to consult with a CCO provider. The treating provider may continue with care of the member until a CCO provider is reached or one of the criteria is met.
(6) The CCO's responsibility for post-stabilization care it has not authorized ends when:
(a) The participating provider with privileges at the treating hospital assumes responsibilities for the member's care;
(b) The participating provider assumes responsibility for the member's care through transfer;
(c) A CCO representative and the treating provider reach an agreement concerning the member's care; or
(d) The member is discharged.
(7) CCOs shall have methods for tracking inappropriate use of urgent and emergency care and shall take action, including individual member counseling, to improve appropriate use of urgent and emergency care services. In partnership with CCOs, DCOs shall take action to improve appropriate use of urgent and emergency care settings for dental health care.
(a) CCOs shall educate members about how to appropriately access care from emergency rooms, urgent care and walk-in clinics, non-traditional health care workers, and less intensive interventions other than their primary care home;
(b) CCOs shall apply and employ innovative strategies to decrease unnecessary hospital utilization.
(8) CCOs must limit charges to members for post-stabilization care services to an amount no greater than what the CCO would charge the member if he or she had obtained the services through the CCO. For purposes of cost sharing, post stabilization care services begin upon inpatient admission.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3145

RULE TITLE: Community Health Assessment and Community Health Improvement Plans

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) Pursuant to ORS 414.627 to the extent practicable, CCOs shall partner with their local public health authority, local mental health authority, and hospital systems to develop a shared Community Health Assessment (CHA) process including conducting the assessment and development of the resulting Community Health Improvement Plan (CHP).

(2) CCOs shall work with the Authority to identify the components of the CHA. CCOs are encouraged to partner with their local public health authority, hospital system, type B Area Agency on Aging, APD field office and local mental health authority, the Early Learning Council, the Youth Development Council, and school health providers in the region using existing resources when available and avoiding duplication where practicable.

(3) In developing and maintaining a health assessment, CCOs shall meaningfully and systematically engage representatives of critical populations and community stakeholders to create a plan for addressing community health needs that build on community resources and skills and emphasizes innovation including, but not limited to, the following:

(a) Emphasis on disproportionate, unmet, health-related need;

(b) Emphasis on primary prevention;

(c) Building a seamless continuum of care;

(d) Building community capacity;

(e) Emphasis on collaborative governance of community benefit.

(4) The CCO requirements for conducting a CHA and CHP will be met for purposes of ORS 414.627 if they substantially meet the community health needs assessment requirement of the federal Patient Protection and Affordable Care Act, 2010 Section 9007, and the Public Health Accreditation Board CHA and CHP requirements for local health departments and the AAA and local mental health authority in the process.

(5) The CCO's CAC shall oversee the CHA and adopt a plan to serve as a strategic population health and health care system service plan for the community served by the CCO. The Council shall annually publish a report on the progress of the CHP.

(6) The CHP adopted by the Council shall describe the scope of the activities, services, and responsibilities that the CCO shall consider upon implementation. The activities, services, and responsibilities defined in the CHP may include, but are not limited to:

(a) Analysis and development of public and private resources, capacities, and metrics based on ongoing community health assessment activities and population health priorities;

(b) Health policy;

(c) System design;

(d) Outcome and quality improvement;

(e) Integration of service delivery;

(f) Workforce development; and

(g) Public Health Accreditation Board standards for CHPs.

(7) CCOs and their participating providers shall work together to develop best practices of culturally and linguistically appropriate care and service delivery to eliminate health disparities and improve member health and well-being.

(8) CCOs and their CAC shall collaborate with the Authority's Office of Equity and Inclusion to develop meaningful baseline data on health disparities. CCOs shall include in the CHA identification and prioritization of health disparities

among CCOs' diverse communities, including those defined by race, ethnicity, language, health literacy, age, disability, gender identity, sexual orientation, behavioral health status, geography, or other factors in their service areas such as type of living setting including, but not limited to, home independent support living, adult foster home, or homeless. CCOs shall collect and maintain data on race, ethnicity, and primary language for all members on an ongoing basis in accordance with standards established by the Authority. CCOs shall also include representatives of populations experiencing health disparities in CHA and CHP prioritization. CCOs shall track and report on any quality measure by these demographic factors and shall develop, implement, and evaluate strategies to improve health equity among members. CCOs shall make this information available by posting on the web.

(9) To the extent practicable, CCOs shall:

(a) Base the CHP on research including research into adverse childhood experiences;

(b) Evaluate the adequacy of the existing school-based health center (SBHC) network to meet the specific pediatric and adolescent health care needs in the community and make recommendations to improve the SBHC system;

(c) Improve the integration of all services provided to meet the needs of children, adolescents, and families;

(d) Address primary care, behavioral and oral health, promotion of health and prevention, and early intervention in the treatment of children and adolescents;

(e) With the development of its CHP SBHCs, school nurses, school mental health providers, and individuals representing child and adolescent health services shall be included.

(10) CCOs shall develop and review and update its CHA and plan at least every five years to ensure the provision of all medically appropriate covered coordinated care services including urgent care and emergency services, preventive, community support, and ancillary services in those categories of services included in CCO contracts or agreements with the Authority.

(11) CCOs shall communicate these policies and procedures to providers, regularly monitor providers' compliance, and take any corrective action necessary to ensure compliance. CCOs shall document all monitoring and corrective action activities.

(12) If there is more than one CCO in a community, the CCOs and their community partners may work together to develop one shared CHA and one shared CHP.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3150

RULE TITLE: Health-Related Services

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) Health-related services that fall under the category of OAR 410-141-3000 section (36)(b) must also meet the following criteria:

(a) Be designed to improve health quality;

(b) Increase the likelihood of desired health outcomes in a manner that is capable of being objectively measured and produce verifiable results and achievements;

(c) Be directed toward either individuals or segments of members, or provide health improvements to the population beyond those enrolled without additional costs for the non-members; and

(d) Be based on any of the following:

(A) Evidence-based medicine; or

(B) Widely accepted best clinical practice; or

(C) Criteria issued by accreditation bodies, recognized professional medical associations, government agencies, or other national health care quality organizations.

(2) As defined in 45 CFR 158.150, health-related services shall be primarily designed to meet at least one of the following criteria:

(a) Improve health outcomes compared to a baseline and reduce health disparities among specified populations;

(b) Prevent avoidable hospital readmissions through a comprehensive program for hospital discharge;

(c) Improve patient safety, reduce medical errors, and lower infection and mortality rates;

(d) Implement, promote, and increase wellness and health activities;

(e) Support expenditures related to health information technology and meaningful use requirements necessary to accomplish the activities above that are set forth in 45 CFR 158.151 that promote clinic community linkage and referral processes or support other activities as defined in 45 CFR 158.150.

(3) A medical service covered under the State Plan may not be categorized as an activity that improves health care quality, as defined in 45 CFR 158.150 and 45 CFR 158.151.

(4) CCOs have the ability to identify and provide health-related services that meet the needs of their members and their communities, which may not be included in the list of examples below. Health-related services may include but are not limited to:

(a) Training and education for health improvement or management, including, but not limited to, classes on healthy meal preparation, diabetes and self-management curriculum;

(b) Care coordination, navigation, or case management activities not otherwise covered under State Plan benefits, including, but not limited to, high utilizer intervention programs;

(c) Home and living environment items or improvements not otherwise covered by 1915 Home and Community Based Services authorities, including, but not limited to, non-Durable Medical Equipment [DME] items to improve mobility, access, hygiene, or other improvements to address a particular health condition such as an air conditioner, athletic shoes, or other special clothing;

(d) Transportation not covered under State Plan benefits, including, but not limited to, transportation for non-medical purposes;

(e) Programs to improve community or public health, including, but not limited to, farmers' market in a "food desert," workforce development;

(f) Housing supports related to social determinants of health, including, but not limited to, temporary housing or shelter, utilities, or critical repairs;
(g) Assistance with food or other social resources, including, but not limited to, supplemental food, referral to job training or social services; and
(h) Other non-covered services that comport with the definition of health-related services in OAR 410-141-3000.
(5) CCOs have the flexibility to identify and provide health-related services beyond the list of examples in 45 CFR 158.150 and 45 CFR 158.151. Expenditures and activities that may not be included as an activity that improves health care quality are:
(a) Those that are designed primarily to control or contain costs;
(b) Those that otherwise meet the definitions for quality improvement activities but that were paid for with grant money or other funding separate from revenue received through a CCO's contract;
(c) Those activities that may be billed or allocated by a provider for care delivery and that are, therefore, reimbursed as clinical services;
(d) Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD-10 codes sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended;
(e) That portion of the activities of health care professional hotlines that do not meet the definition of activities that improve health quality;
(f) All retrospective and concurrent utilization review;
(g) Fraud prevention activities;
(h) The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;
(i) Provider credentialing;
(j) Costs associated with calculating and administering individual member incentives; and
(k) That portion of prospective utilization that does not meet the definition of activities that improve health quality.
(6) MCEs shall use the definition of health-related services, set forth in OAR 410-141-3000, in their policies and procedures (P&Ps). These P&Ps shall be written in collaboration with the Authority and are intended for administration of health-related services as authorized by the CCO. Health-related services P&Ps shall encourage transparency and provider and member engagement, reflect streamlined administrative processes that do not create unnecessary barriers, and provide for accountability.
(7) CCO health-related services policies shall:
(a) Describe how members, communities, and primary care teams are engaged;
(b) Allow professionals outside of the primary care team to render and coordinate health-related services efficiently;
(c) Provide guidance on how professionals request funding for health-related services;
(d) Provide processes to capture individual flexible services that are cost-effective services offered to individual members to supplement covered benefits within the treatment plan and clinical record as specified in OAR 410-141-3180;
(e) Provide description of process to notify individual members of the outcome of health-related services requests;
(f) Describe review processes for decision making that are separate from CCO prior authorization protocols;
(g) Describe how other Medicaid services are considered, coordinated, and facilitated between the CCO and other providers to ensure improved health outcomes for the member;
(h) Describe how community resources, services and resources not funded by Medicaid, are considered and coordinated between the CCO and community partners to ensure improved health outcomes for the member and ensure Medicaid is the payer of last resort;
(i) Describe the data collection and tracking reporting plan;
(j) Efficiently and effectively reduce costs and improve care and validate that no cost sharing is required and that no

administrative burden is imposed on the member or community;
(k) Provide clear accountability for service delivery;
(L) Allow for consideration of any health-related services requested; and
(m) Not limit the range of possible health-related services, if the non-covered services comports with the definition of health-related services in OAR 410-141-3000.
(8) Flexible services, which are health-related services provided to individual members, shall be consistent with the member's treatment plan as developed by the member's care team and agreed to by the CCO. The care team and the CCO shall work with the member and, as appropriate, the family of the member in determining the health-related services needed to supplement the member's care. These services shall be documented in the member's treatment plan and clinical record.
(9) Community benefit initiatives, which are health-related services provided on a community based level, that are initiated by the CCO shall for documentation purposes be included in the CCOs' Transformation and Quality Strategy mid-year update and annual reports beginning in 2019. Community benefit initiatives may not be documented in a treatment plan or clinical record.
(10) CCOs shall submit their financial reporting for health-related services as directed through the CCO contract and in compliance with 42 CFR 438.8 Medical Loss Ratio (MLR).
(11) As allowed under 42 CFR 438.6(e), MCEs may offer additional services that are separate from health-related services and delivered at the complete discretion of the CCO.
(12) With regard to requests for individual flexible services:
(a) A refusal of an individual flexible service request is not an "adverse benefit determination." CCOs shall have written procedures to acknowledge the receipt, disposition, and documentation of each grievance from members as specified in 42 CFR 438.402-408 and OAR 410-141-3225 through 3255. CCOs shall provide members with a written notification of a refusal of individual flexible services request and shall copy any representative of the member and any provider who made or participated in the request on the member's behalf;
(b) The written notification shall inform the member and provider of the member's right to file a grievance in response to the outcome.
(13) Except as provided in section (12), members have no appeal or hearing rights in regard to a refusal of a health-related services request.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 413.042

REPEAL: 410-141-3160

RULE TITLE: Integration and Care Coordination

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) In order to achieve the objectives of providing MCE members integrated person-centered care and services, MCEs shall assure that physical, behavioral, and oral health services are consistently provided to members in all age groups and all covered populations when medically appropriate and consistent with the needs identified in the community health assessment (CHA) and community health improvement plan (CHP).

(2) MCEs shall develop, implement, and participate in activities supporting a continuum of care that integrates physical, behavioral, and oral health interventions in ways that address the whole person and serve members in the most integrated setting appropriate to their needs.

(3) At a minimum, populations shall include members with special health needs, older adults, individuals who are blind, deaf, hard of hearing or with other disabilities, members who have complex medical needs, multiple chronic conditions, mental illness, or chemical dependency, or receive Medicaid-funded long-term care or long-term services and supports as defined in OAR 410-141-3000. Children and youth shall be provided intensive care coordination and behavioral health services according to presenting needs.

(4) Upon initial enrollment with the CCO, the MCE shall conduct an initial health risk screening for each new member, which is different from the assessment of special health care needs. This screening shall be completed and documented within 90 days of the effective date of enrollment for all new members, or within 30 days when the member is referred or is receiving Medicaid LTC or LTSS, or as quickly as the member's health condition requires. MCEs shall maintain documentation on the health risk screening process used for compliance. If the health risk screening requires additional information from the member, MCEs shall document all attempts to reach the member by telephone and mail, including subsequent attempts to demonstrate compliance.

(5) MCEs shall have processes to ensure review of member's potential need for long-term services and supports and identify appropriate members for referrals to the Department for long-term services and supports.

(6) In an effort to eliminate duplicate efforts, MCEs shall implement procedures to document in the member's record and share the results of its health risk screening identifications appropriate for Intensive Care Coordination/Exceptional Needs Care Coordination (ICC/ENCC) services as defined in 410-141-3000:

(a) With participating medical providers serving the member;

(b) With the state or other MCEs serving the enrollee;

(c) With members receiving Medicaid-funded long-term care or long-term services and supports and their case manager and their LTSS provider, if approved by the member; and

(d) With Medicare Advantage plans serving dual eligible members;

(e) Information sharing shall be consistent with ORS 414.679 and applicable privacy requirements.

(7) MCEs shall ensure that members assessed with high health needs, multiple chronic conditions, behavioral health issues, or receiving Medicaid funded long-term care or long-term services and supports are:

(a) Provided ICC services in accessing and managing appropriate preventive, health, behavioral health, remedial and supportive care and services;

(b) Provided contact information for any ICC staff or formally designated person or entity with the primary responsibility for coordinating the services with the member;

(c) MCEs shall monitor subcontractors to ensure language and disability access are provided consistently across services and settings of care.

(8) For members with special health care needs determined through a health risk screening, MCEs shall have a process to allow enrollees direct access to a specialist, e.g., a standing referral or an approved number of visits, as appropriate for the member's condition and identified needs.
(9) MCEs shall have processes to receive referrals for members receiving long-term care or long-term services and supports from the Department and referrals for intensive care coordination within 30 days, or as quickly as the member's health condition requires.
(10) MCEs shall produce a treatment or service plan for members with special health care needs, including members receiving LTC or LTSS that are determined through a health assessment to need a course of treatment or regular care monitoring:
(a) Such treatment plans shall be developed with any providers caring for the member, including any community-based support services and LTSS providers; and
(b) Include consultations with any specialist caring for the member and Department long-term care or long-term services and supports, providers, or case managers:
(c) MCEs shall share information as needed to prevent duplication of efforts in assessments, care planning, and care coordination as follows:
(A) With the Department Aging and People with Disabilities and the Office of Developmental Disability Services case managers for members with Medicaid long-term care or long-term services and supports;
(B) Skilled nursing facilities when applicable;
(C) With other MCEs serving members; and
(D) With Medicare Advantage Plans serving dual eligible members.
(d) MCEs shall use and require its provider network to use individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs, including members with serious and persistent mental illness receiving home and community-based services covered under the state's 1915(i) State Plan Amendment and those receiving Department Medicaid-funded long-term care services and supports. Plans shall reflect the member's preferences and goals, and if appropriate, family or caregiver preferences and goals to ensure engagement and satisfaction and ensure authorization of services reflects rules outlined in OAR 410-141-3225 MCE Service Authorization.
(11) MCEs shall coordinate services between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays that reduce duplication of assessment and care planning activities:
(a) With the services the enrollee receives from any other MCE;
(b) With the services the enrollee receives in FFS Medicaid; and
(c) With the services the enrollee receives from community and social support providers.
(12) MCEs shall develop evidence-based or innovative strategies for use within their delivery system networks to ensure access to and provision of integrated and coordinated care, especially for members with ICC needs.
(13) To the maximum extent feasible, CCOs shall develop and use Patient Centered Primary Care Home (PCPCH) capacity by implementing a network of PCPCHs:
(a) PCPCHs shall become the focal point of coordinated and integrated care so that members have a consistent and stable relationship with a care team responsible for comprehensive care management;
(b) MCEs shall develop mechanisms that encourage providers to communicate and coordinate care with the PCPCH in a timely manner, using electronic health information technology where available;
(c) MCEs shall engage other primary care provider (PCP) models to be the primary point of care and care management for members where there is insufficient PCPCH capacity.
(14) If an MCE implements other models of patient-centered primary health care in addition to the use of PCPCH, the MCE shall ensure member access to coordinated care services that provide effective wellness and prevention, coordination of care, active management and support of individuals with special health care needs, a patient and family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient's physical and behavioral health care needs. The MCE shall:

(a) Demonstrate that each member has a primary care provider or primary care team that is responsible for coordination of care and transitions and that each member has the option to choose a primary care provider of any eligible MCE participating provider type;
(b) Ensure that each member has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. The member must be provided information on how to contact their designated person or entity;
(c) MCEs shall develop services and supports for primary care that are geographically located as close as possible to the member's residence and are, if available, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations. MCEs shall ensure that all other services and supports are provided as close to the member's residence as possible:
(A) MCE members who are Indians (AI/AN) shall be permitted to select an Indian health care provider (IHCP) that is participating as a primary care provider within the network of the MCE or may select an out-of-network IHCP from whom the enrollee is otherwise eligible to receive such primary care services;
(B) An out-of-network IHCP may refer an MCE member who is an Indian to an in-network provider without prior authorization or referral from a participating provider.
(d) MCEs shall maintain contracts with providers of residential chemical dependency treatment services and notify the Authority within 30 days of executing new contracts;
(e) MCEs shall maintain a contractual relationship with any dental care organizations necessary to provide adequate access to oral services in the area where members reside;
(f) MCEs shall assess the needs of its membership and make available supported employment and assertive community treatment services available when members are referred and eligible. Appropriate ACT providers are those that meet the requirements in OAR 309-019-0225 through 309-019-0255. Appropriate supported employment services providers are those that meet the requirements in OAR 309-019-0270 through 309-019-0320. When no appropriate provider is available, the MCE shall consult with the Division and develop an approved plan to make supported employment and assertive community treatment services available;
(g) MCEs shall report the number of individuals with SPMI who receive supported employment services at a frequency to be determined by OHA.
(15) MCEs shall have adequate, timely, and appropriate access to hospital and specialty services. MCEs shall establish hospital and specialty service agreements that include the role of patient-centered primary care homes and that specify processes for requesting hospital admission or specialty services, performance expectations for communication, and medical records sharing for specialty treatments at the time of hospital admission or discharge for after-hospital follow up appointments.
(16) MCEs shall demonstrate how hospitals and specialty services shall be accountable to achieve successful transitions of care. MCEs shall ensure members are transitioned out of hospital settings into the most appropriate independent and integrated community settings. This includes transitional services and supports for children, adolescents, and adults with serious behavioral health conditions facing admission to or discharge from acute psychiatric care, residential treatment settings, and the state hospital.
(17) When a member's care is being transferred from one MCE to another or for OHP clients transferring from fee-for-service or PHP to an MCE, the MCE shall make every reasonable effort within the laws governing confidentiality to coordinate (including but not limited to ORS 414.679) transfer of the OHP client into the care of an MCE participating provider.
(18) The MCE shall implement systems to assure and monitor transitions in care so that members receive comprehensive transitional care and improve members' experience of care and outcomes, particularly for transitions between hospitals and long-term care, and ensure providers and subcontractors receive information on the process for members accessing care coordination.
(19) For members who are discharged to post hospital extended care at the time of admission to a skilled nursing facility (SNF), the MCE shall notify the appropriate Department office and begin appropriate discharge planning. The MCE shall

pay for the full 20-day post-hospital extended care benefit when appropriate, if the member was enrolled in the MCE during the hospitalization preceding the nursing facility placement:
(a) MCEs shall notify the SNF and the member no later than two business days before discharge from post-hospital extended care (PHEC);
(b) For members who are discharged to Medicare Skilled Care, the MCE shall notify the appropriate Department office when the MCE learns of the admission. Goals of discharge planning coordination include reducing duplication of assessment and care planning activities and services by multiple entities involved in the member's care;
(c) MCEs shall coordinate transitions to Department Medicaid-funded long-term care services and supports, after the PHEC is exhausted, by communicating with local Department offices when members are being discharged from an inpatient hospital stay or transferred between different long-term care (LTC) settings.
(20) MCEs shall work across provider networks to develop partnerships necessary to allow for access to and coordination with social and support services, including crisis management and community prevention and self-managed programs:
(a) The MCE shall establish procedures for coordinating member health services and how it will work with long-term care providers or facilities to develop partnerships necessary to allow for access to and coordination of MCE services with long-term care services and crisis management services;
(b) MCEs shall develop a Memorandum of Understanding (MOU) or contract with the local type B Area Agency on Aging or the local office of the Department's APD, detailing their system coordination agreements regarding members receiving Medicaid-funded long-term care or long-term services and supports;
(c) MCEs shall establish agreements with the Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs) operating in the service area, consistent with ORS 414.153, to maintain a comprehensive and coordinated behavioral health delivery system and to ensure member access to behavioral health services, some of which are not provided under the global budget.
(21) A CCO may cover and reimburse inpatient psychiatric services, not including substance use disorder treatment at an Institution for Mental Diseases (IMD) as defined in 42 CFR 435.1010. (See OAR 410-141-3000 for the definition of an IMD.) The state may make a monthly capitation payment to a CCO using Medicaid capitated funds for inpatient psychiatric services for an alternative service or setting, incorporating all the following requirements as defined in 42 CFR 438.6(e):
(a) For members aged 21-64;
(b) As inpatient psychiatric services for a short-term stay of no more than 15 days during the period of the monthly capitation payment;
(c) The provision of inpatient psychiatric services in an IMD shall meet the requirements for in lieu of services as defined in 42 CFR 438.6(e)(2)(i) through (iii):
(A) The alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the state plan;
(B) The CCO must offer the option to access the state plan services and may not require a member to use the IMD as an alternative service or setting;
(C) The approved in lieu of services are authorized and identified in the CCO contract and may be offered to members at the CCO's option.
(22) If the member is living in a Department Medicaid funded long-term care (LTC) nursing facility or community-based care facility or other residential facility, the MCE shall communicate with the member and the Department Medicaid funded long-term care provider or facility about integrated and coordinated care services.
(23) An MCE shall demonstrate that participating providers have the tools and skills necessary to communicate in a linguistically and culturally appropriate fashion with members and their families or caregivers and to facilitate information exchange between other providers and facilities (e.g., addressing issues of health literacy, language interpretation, having electronic health record capabilities).
(24) The MCE shall communicate its integration and coordination policies and procedures to participating providers,

regularly monitor providers' compliance, and take any corrective action necessary to ensure compliance. MCEs shall document all monitoring and corrective action activities.
(25) MCEs shall ensure that members receiving services from extended or long-term psychiatric care programs, such as secure residential facilities, shall receive follow-up services as medically appropriate to facilitate discharge as soon as reasonably possible. MCEs shall coordinate the care of members that enter the Oregon State Hospital and develop agreements with community mental health programs regarding the management of adults who were members upon entering the state hospital and are transitioning from the Oregon State Hospital.
(26) MCEs shall coordinate a member's care even when services or placements are outside the MCE service area. MCE assignment is based on the case member's residence and referred to as county of origin or jurisdiction. Temporary placements by the Authority, Department, or health services placements for services including residential placements may be located out of the service area; however, the MCE shall coordinate care while in placement and discharge planning for return to the county of origin or jurisdiction. For out of area placements, an out of area exception shall be made for the member to retain the MCE enrollment in the county of origin or jurisdiction, while the member's placement is a temporary residential placement elsewhere. For program placements in Child Welfare, BRS, OYA, and PTRS, refer to OAR 410-141-3050 for program specific rules.
(27) Except as provided in OAR 410-141-3050, MCEs shall coordinate patient care, including care required by temporary residential placement outside the MCE service area or out-of-state care in instances where medically necessary specialty care is not available in Oregon:
(a) MCE enrollment shall be maintained in the county of origin with the expectation of the MCE to coordinate care with the out of area placement and local providers;
(b) The MCE shall coordinate the discharge planning when the member returns to the county of origin.
(28) MCEs shall coordinate and authorize care, including instances when the member's medically appropriate care requires services and providers outside the MCE's contracted network, in another area, out-of-state, or a unique provider specialty not otherwise contracted. The MCE shall pay the services and treatment plan as a non-participating provider pursuant to OAR 410-120-1295. Authorization of services shall reflect rules outlined in OAR 410-141-3225 MCE Service Authorization.
(29) MCEs shall ensure that any staff member responsible for denying or reviewing denials of requests for referral is a health care professional, as defined in OAR 410-120-0000, 410-141-3225, or 410-141-3240, and shall ensure a notice of action/adverse benefit determination notice is issued for an adverse benefit determination or service authorization denial, including request for referrals that are denied.
(30) MCEs shall coordinate with Community Emergency Service Agencies, including but not limited to police, courts, juvenile justice, corrections, LMHAs, and CMHPs, to promote an appropriate response to members experiencing a behavioral health crisis and to prevent inappropriate use of the emergency department or jails.
(31) MCEs shall accept FFS authorized services, medical, and pharmacy prior authorizations; ongoing services where a FFS prior authorization is not required, and services authorized by the Division's Medical Management Review Committee. This shall occur within 90 days or until the MCE can establish a relationship with the member and develop an evidence-based, medically appropriate coordinated care plan, whichever is later. The exception is when customized equipment, services, procedures, or treatment protocol require service continuation for no less than six months.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610–414.685

REPEAL: 410-141-3170

RULE TITLE: Intensive Care Coordination (ICC) Services (Exceptional Needs Care Coordination (ENCC))

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) MCEs are responsible for intensive care coordination (ICC) services, otherwise known as Exceptional Needs Care Coordination (ENCC). Even if the MCE uses another term, these rules set forth the elements and requirements for ICC services. Where the term ENCC appears in rule or contract, it shall be given the meaning in this rule.

(2) MCEs shall make ICC services available to members identified with special health care needs, older adults, individuals who are blind, deaf, hard of hearing or other disabilities, older adults, or members with complex medical needs, high health care needs, multiple chronic conditions, behavioral health issues including chemical dependency, or those receiving Medicaid-funded long-term care or long-term services and supports receiving home and community-based services (HCBS) under the state's 1915(i), 1915(j), or 1915(k)State Plan Amendments or the 1915(c) HCBS waivers. Children and youth shall be provided intensive care coordination and behavioral health services according to presenting needs.

(3) The member, member's representative, HCBS provider, provider, or other medical personnel serving the member or the member's Medicaid Long Term Care (LTC) or Long Term Service and Supports (LTSS) case manager may refer or self-refer the member for a health risk screening for ICC services.

(4) MCEs shall respond to requests for ICC services with an initial response made by the next business day following the request.

(5) Upon initial enrollment with the CCO, the MCE shall conduct an initial health risk screening for each new member, which is different from the assessment of special health care needs. This screening shall be completed and documented within 90 days of the effective date of enrollment for all new members, or within 30 days when the member is referred or is receiving Medicaid LTC or LTSS, or as quickly as the member's health condition requires. MCEs shall maintain documentation on the risk screening process used for compliance. If the risk screening requires additional information from the member, MCEs shall document all attempts to reach the member by telephone and mail, including subsequent attempts, to demonstrate compliance.

(6) MCEs shall have processes to ensure review of the member's potential need for long-term services and supports and identify appropriate members for referrals to DHS for long-term services and supports.

(7) MCEs shall implement procedures to share the results of its screening identifications and treatment plans appropriate for ICC services with participating providers serving the member and those identified in section (3). Information sharing shall be consistent with ORS 414.679 and applicable privacy requirements.

(8) MCEs shall implement an information sharing process to reduce duplication of services among entities serving members as follows:

(a) With DHS Aging and People with Disabilities and the Office of Developmental Disability Services Case Managers for members enrolled with Medicaid long-term care or long-term services and supports;

(b) With other MCEs serving members; and

(c) Skilled Nursing Facilities when applicable; and

(d) With Medicare Advantage plans serving dual eligible members.

(9) Such care coordination activities include:

(a) Early identification of members eligible for ICC services;

(b) Assistance to ensure timely access to medical providers and capitated services;

(c) Coordination with medical, LTC, and LTSS providers to ensure consideration is given to unique needs in treatment

planning;
(d) Assistance to medical providers with coordination of capitated services and discharge planning; and
(e) Aid with coordinating necessary and appropriate linkage of community support and social service systems with medical care systems;
(f) Subcontractors shall be monitored to ensure language and disability access are provided consistently across services and settings of care.
(10) MCEs shall implement processes for documentation of ICC services and the development of a treatment plan for a member identified with special health care needs.
(11) MCEs shall share treatment plan information as needed with DHS Aging and People with Disabilities and Office of Developmental Disability Services for members receiving Medicaid-funded long-term care or long-term services and supports, with other MCEs serving the member, and with Medicare Advantage plans serving dual eligible members.
Each treatment plan shall be:
(a) Developed by the member's designated provider with the member's participation;
(b) Include consultations with any specialist caring for the member and DHS long-term services and supports providers and case managers;
(c) Approved by the MCE in a timely manner if MCE approval is required;
(d) In alignment with rules outlined in OAR 410-141-3225 MCE Service Authorization; and
(e) In accordance with any applicable quality assurance and utilization review standards.
(12) The member, member's representative, medical provider, other medical personnel serving the member, or the member's DHS case manager may request ICC services.
(13) MCEs shall have processes to receive referrals for health care assessments.
(14) MCEs shall refer members to ICC for a health assessment within 30 days when the member referred is receiving Medicaid LTSS or as quickly as the member's health condition requires.
(15) MCEs shall respond to requests for ICC services with an initial response made by the next business day following the request.
(16) MCEs shall make ICC services available to coordinate the provision of these services to members who exhibit inappropriate, disruptive, or threatening behaviors in a provider's office or clinic or other health care setting.
(17) MCEs shall periodically inform all participating providers of the availability of ICC and other support services available for members and provide training for patient centered primary care homes and other primary care providers' staff.

STATUTORY/OTHER AUTHORITY: 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3180

RULE TITLE: Record Keeping and Use of Health Information Technology

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) MCEs shall have written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the security of records as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC §1320-d et seq., the federal regulations implementing the Act, and complete clinical records that document the coordinated care services received by the members. MCEs shall communicate these policies and procedures to subcontractors. MCEs shall regularly monitor its subcontractors' compliance and take any corrective action necessary. MCEs shall document all monitoring and corrective action activities. These policies and procedures shall ensure that records are secured, safeguarded, and stored in accordance with applicable Oregon Revised Statutes and Oregon Administrative Rules.

(2) A member must have access to the member's personal health information in the manner provided in 45 C.F.R. 164.524 and ORS 179.505(9) so the member may share the information with others involved in the member's care and make better health care and lifestyle choices. MCE's participating providers may charge the member for reasonable duplication costs, as set forth in OAR 943-014-0030, when the member requests copies of their records.

(3) Notwithstanding ORS 179.505, an MCE, its provider network, and programs administered by the Department's Aging and People with Disabilities shall use and disclose member information for purposes of service and care delivery, coordination, service planning, transitional services, and reimbursement in order to improve the safety and quality of care, lower the cost of care, and improve the health and well-being of the members.

(4) An MCE and its provider network shall use and disclose sensitive diagnosis information including HIV and other health and behavioral health diagnoses within the MCE for the purpose of providing whole-person care. Individually identifiable health information must be treated as confidential and privileged information subject to ORS 192.553 to 192.581 and applicable federal privacy requirements. Re-disclosure of individually identifiable information outside of the MCE and the MCE's providers for purposes unrelated to this section or the requirements of ORS 414.625, 414.632, 414.635, 414.638, 414.653 and 414.655 remains subject to any applicable federal or state privacy requirements including the Authority's rules established in OAR 943-014-0000 through 0070 for matters that involve privacy and confidentiality and privacy of members protected information.

(5) The MCE must document its methods and findings to ensure across the organization and the network of providers there is documentation of the following coordinated care services and supports:

(a) Each member has a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery;

(b) The supportive and therapeutic needs of the member are addressed in a holistic fashion, using patient centered primary care homes and individualized care plans to the extent feasible;

(c) Members receive comprehensive transitional care, including appropriate follow-up, when entering and leaving an acute care facility, including acute psychiatric facility, state hospital, or residential care settings for members with mental illness or a Department Medicaid funded long-term care setting, including engagement of the member and family in care management and treatment planning;

(d) Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources; for example, the use of certified or qualified health care interpreters, as defined in ORS 413.550, community health workers, and personal health navigators who meet competency standards established in ORS 414.665 or who are certified by the Home Care Commission under ORS 410.604;

(e) Members have access to advocates; for example, qualified peer wellness specialists, peer-delivered support specialists, personal health navigators, and qualified community health workers who are part of the member's care team to provide assistance that is culturally and linguistically appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services;
(f) Members are encouraged within all aspects of the integrated and coordinated health care delivery system to use wellness and prevention resources and to make healthy lifestyle choices.
(6) MCEs shall facilitate the adoption and use of electronic health records (EHRs) by its provider network. To achieve advanced EHR adoption, MCEs shall:
(a) Identify EHR adoption rates. Rates may be divided by provider type and geographic region;
(b) Develop and implement strategies to increase adoption rates of certified EHRs;
(c) Encourage EHR adoption.
(7) MCEs shall facilitate the adoption and use of electronic health information exchange (HIE) in a way that allows all participating providers to exchange a member's health, behavioral health, and oral health information with any other provider in that MCE.
(8) MCEs shall establish minimum requirements for HIE, including rates of e-prescribing and electronic lab orders, over time.
(9) MCEs shall initially identify their current HIT capacity and develop and implement a plan for improvement in the following areas:
(a) Analytics that are regularly and timely used in reporting to its provider network (e.g., to assess provider performance, effectiveness, and cost-efficiency of treatment);
(b) Quality and utilization reporting to facilitate quality improvement within the MCE as well as to report the data on quality of care that allows the Authority to monitor the MCEs performance;
(c) Patient engagement through HIT, using existing tools such as e-mail; and
(d) Other appropriate uses for HIT (e.g., telehealth, mobile devices).
(10) MCEs shall maintain health information systems that collect, analyze, integrate, and report data and are able to provide information on areas including but not limited to the following:
(a) Names and phone numbers of the member's primary care provider or clinic, primary dentist, and behavioral health provider;
(b) Copies of Client Process Monitoring System (CPMS) enrollment forms;
(c) Copies of long-term psychiatric care determination request forms;
(d) Evidence that the member has been informed of rights and responsibilities;
(e) Complaint and appeal records;
(f) Disenrollment requests for cause and the supporting documentation;
(g) Coordinated care services provided to enrollees through an encounter data system; and
(h) Based on written policies and procedures, the record keeping system developed and maintained by MCEs and their participating providers shall include sufficient detail and clarity to permit internal and external review to validate encounter submissions and to assure medically appropriate services are provided consistent with the documented needs of the member. The system shall conform to accepted professional practices and facilitate an adequate system to allow the MCE to ensure that data received from providers is accurate and complete by:
(A) Verifying the accuracy and timeliness of reported data;
(B) Screening the data for completeness, logic, and consistency; and
(C) Collecting service information in standardized formats to the extent feasible and appropriate.
(11) MCEs and their provider network shall cooperate with the Authority, the Department of Justice Medicaid Fraud Control Unit (MFCU), and CMS or other authorized state or federal reviewers for purposes of audits, inspection, and examination of members' clinical records, whether those records are maintained electronically or in physical files. Documentation must be sufficiently complete and accurate to permit evaluation and confirmation that coordinated care services are authorized and provided, referrals are made, and outcomes of coordinated care and referrals are

sufficient to meet professional standards applicable to the health care professional and meet the requirements for health oversight and outcome reporting in these rules.
(12) Across the MCE's provider network, all clinical records shall be retained for a minimum of ten years after the date of services for which claims are made. Contractors shall maintain any other records, books, documents, papers, plans, records of shipments, and payments and writings, whether in paper, electronic, or other form that are pertinent in a manner that clearly documents contractor's performance. All clinical records, financial records, other records, books, documents, papers, plans, records of shipments, and payments and writings of the contractor whether in paper, electronic, or other form are collectively referred to as "Records." If an audit, litigation, research and evaluation, or other action involving the records is started before the end of the ten-year period, the clinical records must be retained until all issues arising out of the action are resolved.
(13) MCEs shall allow access to the agencies listed in section (12) of all audit records and its subcontractors and participating provider's records to allow the listed agencies to perform examinations and audits and make excerpts and transcripts and to evaluate the quality, appropriateness, and timeliness of services.
(14) MCEs shall allow access to the entities listed in section (12) at any time to inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. MCEs subject to an audit under this section shall retain records for ten years from the final date of the contract period or from the date of completion of the most recent state audit, whichever is later. MCEs shall retain and keep accessible all records for a minimum of ten years. County agencies participating in the Medicaid program are subject to whichever record retention requirement is longer between this rule and OAR chapter 166, division 150 County and Special District Retention Schedule.
(15) MCEs must maintain yearly logs of all appeals and grievances for ten years following requirements specified in OAR 410-141-3255.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3200

RULE TITLE: Outcome and Quality Measures

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) CCOs shall report to the Authority its health promotion and disease prevention activities, national accreditation organization results, and HEDIS measures as required by DCBS in OAR 836-053-1000. A copy of the reports may be provided to the Authority's Performance Improvement Coordinator concurrent with any submission to DCBS.

(2) The contractor shall inform the Authority if it has been accredited by a private independent accrediting entity. If the contractor has been so accredited, the contractor shall authorize the private independent accrediting entity to provide the Authority a copy of its most recent accreditation review.

(3) As required by Health System Transformation, CCOs shall be accountable for performance on outcomes, quality, and efficiency measures incorporated into the CCO's contract with the Authority. The measures are adopted by the Metrics and Scoring Committee using a public process. Information can be requested from the Authority or viewed online at http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Metrics-Scoring-Committee.aspx.

(4) CCOs shall address objective outcomes, quality measures, and benchmarks for ambulatory care, inpatient care, behavioral healthcare, oral health care, and all other health services provided by or under the responsibility of the CCO as specified in the CCO's contract with the Authority and federal external quality review requirements in CFR 42 §438.350, §438.358, and §438.364.

(5) CCOs shall maintain an effective process for monitoring, evaluating, and improving the access, quality, and appropriateness of services provided to members consistent with the needs and priorities identified in the CCO's community health assessment, community health improvement plan, and the standards in the CCO's contract. CCOs shall have in effect mechanisms to:

(a) Detect both underutilization and overutilization of services;

(b) Evaluate performance and customer satisfaction consistent with CCO contractual requirements, relevant Oregon Administrative Rules, and provide documentation of implementation of interventions to achieve improvement in the access to and quality of care to the Authority and the Authority contracted External Quality Review Organization (EQRO);

(c) Evaluate grievance, appeals, and contested case hearings consistent with OAR 410-141-3245 through 410-141-3248; and

(d) Assess the quality and appropriateness of coordinated care services provided to all members with identified special health care needs including those who are aged, blind, or disabled or who have high health care needs, multiple chronic conditions, mental illness, or Substance Use Disorders (SUD); who receive Medicaid funded long-term care or long-term services and supports benefits; or who are children receiving CAF (Child Welfare) or OYA services.

(6) CCOs shall implement policies and procedures that assure it collects timely data including health disparities and other data required by rule or contract that allows the CCO to conduct and report on its outcome and quality measures and report its performance. CCOs shall submit to the Authority the CCO's annual written evaluation of outcome and quality measures established for the CCO or other reports as the Authority may require in response to the measures adopted by the Metrics and Scoring Committee.

(7) CCOs shall adopt practice guidelines consistent with 42 CFR 438.236 and the CCO contract that addresses assigned contractual responsibilities for physical health care, behavioral healthcare, or oral health care; goals to increase care coordination with other MCEs, the state, or other providers as outlined in OAR 410-141-0160 and 410-141-3160; and concerns identified by members or their representatives and to implement changes that have a favorable impact on

health outcomes and member satisfaction in consultation with its community advisory council or clinical review panel.
(8) CCOs shall be accountable for both core and transformational measures of quality and outcomes:
(a) Core measures will be triple-aim oriented measures that gauge CCO performance against key expectations for care coordination, consumer satisfaction, quality, and outcomes. The measures shall be uniform across CCOs and shall encompass the range of services included in CCO global budgets (e.g., behavioral health, hospital care, women's health) or MHO and DCO contracts;
(b) Transformational metrics shall assess CCO progress toward the broad goals of health systems transformation. This subset may include newer kinds of indicators (for which CCOs have less measurement experience) or indicators that entail collaboration with other care partners.
(9) CCOs shall provide the required data to the All Payer All Claims data system established in ORS 442.464 and 442.466 and the CCO agreement in the manner authorized by OAR 409-025-0130.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3220

RULE TITLE: Accessibility

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) Consistent with the community health assessment and health improvement plan, MCEs must assure that members have access to high quality care. The MCE shall accomplish this developing a provider network that demonstrates communication, collaboration, and shared decision making with the various providers and care settings. The MCE shall develop and implement the assessment and plan over time that meets access-to-care standards and allows for appropriate choice for members. The goal shall be that services and supports shall be geographically as close as possible to where members reside and, to the extent necessary, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations.

(2) MCEs shall ensure access to integrated and coordinated care as outlined in OAR 410-141-3160, which includes access to a primary care provider or primary care team that is responsible for coordination of care and transitions.

(3) In developing its access standards, the MCE shall anticipate access needs so that the members receive the right care at the right time and place, using a patient-centered approach. The MCE provider network shall support members, especially those with behavioral health issues, in the most appropriate and independent setting, including in their own home or independent supported living.

(4) MCEs shall have policies and procedures that ensure 90 percent of their members in each service area have routine travel time or distance to the location of the PCPCH or PCP that does not exceed the community standard for accessing health care participating providers. The travel time or distance to: PCPCHs or PCPs; primary care, adult and pediatric; OB/GYN; behavioral health (mental health and substance use disorder), adult and pediatric; specialists, adult and pediatric; hospital; pharmacy; oral, adult and pediatric; and additional provider types when it promotes the objectives of the Authority may not exceed the following, unless otherwise approved by the Authority:

(a) In urban areas-30 miles, 30 minutes or the community standard, whichever is greater;

(b) In rural areas-60 miles, 60 minutes or the community standard, whichever is greater.

(5) MCEs shall have an access plan that establishes standards for access, outlines how capacity is determined and establishes procedures for monthly monitoring of capacity and access and for improving access and managing risk in times of reduced participating provider capacity. The access plan shall also identify populations in need of interpreter services and populations in need of accommodation under the Americans with Disabilities Act.

(6) MCEs shall make the services it provides including: Primary care, specialists, pharmacy, hospital, vision, ancillary, and behavioral health services or other services as necessary to achieve compliance with the requirements of 42 CFR 438, subpart K as accessible to members for timeliness, amount, duration, and scope as those services are to other members within the same service area. If the MCE is unable to provide those services locally, it must so demonstrate to the Authority and provide reasonable alternatives for members to access care that must be approved by the Authority. MCEs shall have a monitoring system that shall demonstrate to the Authority that the MCE has surveyed and monitored for equal access of members to referral providers of pharmacy, hospital, vision, ancillary, and behavioral health services:

(a) MCEs shall ensure that PCPs screen all eligible members for behavioral health issues to promote prevention, early detection, intervention, and referral to treatment, especially at initial contact or physical exam or at initial prenatal examination, when a member shows evidence of behavioral health issues or when a member over utilizes services;

(b) MCEs must use a universal screening process that assesses members for critical risk factors that trigger intensive care coordination for high-needs members;

(c) If ten or more CCO enrolled members in a CCO region have been referred, are eligible and are appropriate for ACT, and are on a waitlist to receive ACT that has lasted for more than 30 days, CCOs shall take action to reduce the waitlist and serve those individuals by:
(A) Increasing team capacity to a size that is still consistent with fidelity standards; or
(B) By adding additional ACT teams;
(C) When no appropriate provider is available, the MCE shall consult with the Division and develop an approved plan to increase capacity and add additional teams.
(7) MCEs shall have policies and procedures and a monitoring system to ensure that members who are aged, blind, or disabled, or who have complex or high health care needs, multiple chronic conditions, behavioral health issues, or who are children receiving Department or OYA services have access to primary care, oral care (when the MCE or DCO is responsible for oral care), behavioral health providers and referral, and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services.
(8) MCEs shall have policies and procedures that ensure scheduling and rescheduling of member appointments are appropriate to the reasons for and urgency of the visit. The member shall be seen, treated, or referred as within the following timeframes:
(a) Emergency care, immediately or referred to an emergency department depending on the member's condition;
(b) Urgent care, within 72 hours or as indicated in initial screening and in accordance with OAR 410-141-0140;
(c) Well care, within four weeks or within the community standard;
(d) Emergency oral care (when oral care is provided by the MCE or DCO), seen or treated within 24-hours;
(e) Urgent oral care (when oral care is provided by the MCE or DCO), within one to two weeks or as indicated in the initial screening in accordance with OAR 410-123-1060; and
(f) Routine oral care (when oral care is provided by the MCE or DCO), seen for routine care within an average of eight weeks and within 12 weeks or the community standard, whichever is less, unless there is a documented special clinical reason that makes access longer than 12 weeks appropriate;
(g) Non-Urgent behavioral health treatment, seen for an intake assessment within two weeks from date of request.
(9) MCEs shall develop policies and procedures for communicating with and providing care to members who have difficulty communicating due to a medical condition or who are living in a household where there is no adult available to communicate in English or there is no telephone:
(a) The policies and procedures shall provide certified or qualified interpreter services by phone, in person, in MCE administrative offices, especially those of member services and complaint and grievance representatives, and in emergency rooms of contracted hospitals;
(b) MCEs shall ensure the provision of certified or qualified interpreter services for covered coordinated care services including medical, behavioral health, or oral care (when the MCE or DCO is responsible for oral care) visits, and home health visits to interpret for members with hearing impairment or in the primary language of non-English speaking members. All interpreters shall be linguistically appropriate and be capable of communicating in English and the members' primary language and be able to translate clinical information effectively. Interpreter services shall be sufficient for the provider to understand the member's complaint, make a diagnosis, respond to member's questions and concerns, and communicate instructions to the member;
(c) MCEs shall ensure the provision of coordinated care services that are culturally appropriate, i.e., demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect on the members' care;
(d) MCEs shall have written policies and procedures that ensure compliance with requirements of the Americans with Disabilities Act of 1990 in providing access to covered coordinated care services for all members and shall arrange for services to be provided by non-participating referral providers when necessary;
(e) MCEs shall have a plan for ensuring compliance with these requirements and shall monitor for compliance.

STATUTORY/OTHER AUTHORITY: ORS 413.032, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3225

RULE TITLE: MCE Service Authorization

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) Coverage of services is outlined by MCE contract and OHP benefits coverage outlined in OAR 410-120-1210 and 410-120-1160.

(2) A member may access urgent and emergency services 24 hours a day, seven days a week without prior authorization.

(3) The MCE may not require a member to obtain the approval of a primary care physician to gain access to mental health or substance use disorders assessment and evaluation services. A member may self-refer to mental health and substance use disorders services available from the provider network.

(4) Contractors must permit out-of-network IHCPs to refer an MCE-enrolled Indian to a network provider for covered services as required by 42 CFR 438.14(b)(6).

(5) The MCE shall ensure the services are furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid and as described in ORS chapter 414 and applicable administrative rules, based on the Prioritized List of Health Services and OAR 410-120-1160, 410-120-1210, and 410-141-0520.

(6) MCEs may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.

(7) MCEs shall observe required timelines for standard authorizations, expedited authorizations, and specific OHP rule requirements for authorizations for services, including but not limited to residential treatment or substance use disorder treatment services and requirements for advance notice set forth in OAR 410-141-3240 (Notice of Action/Adverse Benefit Determination Notice Requirements).

(8) MCEs may place appropriate limits on a service authorization based on medical necessity and medical appropriateness as defined in OAR 410-120-0000 or for utilization control provided that the MCE:

(a) Ensures the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished;

(b) Authorizes the services supporting individuals with ongoing or chronic conditions or require long-term services and supports in a manner that reflects the member's ongoing need for the services and supports;

(c) Provides family planning services in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20; and

(d) Ensures compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

(9) For authorization of services:

(a) Each MCE shall follow the following timeframes for authorization requests other than for drug services:

(A) For standard authorization requests for services not previously authorized, provide notice as expeditiously as the member's condition requires and no later than 14 days following receipt of the request for service with a possible extension of up to 14 additional days if the following applies:

(i) The member, the member's representative, or provider requests an extension; or

(ii) The MCE justifies to the Authority upon request a need for additional information and how the extension is in the member's interest.

(B) For notice of actions/adverse benefit determinations that affect services previously authorized, the MCE shall mail the notice at least ten days before the date the adverse benefit determination takes effect:

(i) The MCE shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service;
(ii) The MCE may extend the 72-hour period up to 14 days if the member requests an extension or if the MCE justifies to the Authority upon request a need for additional information and how the extension is in the member's interest.
(b) Prior authorization requests for prescription drugs, including a practitioner administered drug (PAD), shall be addressed by the MCEs as follows:
(A) Respond to prior authorizations for prescription drugs within 24 hours as described in CFR 438.210(d)(3) and section 1927(d)(5)(A) of the Social Security Act. A response may include:
(i) A decision to approve or deny the drug;
(ii) A written, telephonic, or electronic request for additional documentation when the prior authorization request lacks sufficient information or documentation to render a decision; or
(iii) A written, telephonic, or electronic acknowledgment of receipt of the prior authorization request that gives an expected timeframe for a decision. An initial response indicating only acceptance of a request shall not delay a decision to approve or deny the drug within 72 hours.
(B) If the response is a request for additional documentation, the MCE shall identify the required documentation and comply within the following timeframes:
(i) The MCE shall issue a decision within 72 hours or as expeditiously as the member's health requires upon receiving the necessary documentation if additional information or documentation is received; and
(ii) The MCE shall deny a request for prior authorization if the necessary additional documentation is not received within 72 hours of the request for additional documentation.
(C) If an emergency situation justifies the immediate medical need for the drug during this review process, an emergency supply of 72 hours or longer shall be made available until the MCE makes a coverage decision.
(c) For members with special health care needs as determined through an assessment requiring a course of treatment or regular care monitoring, each MCE shall have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs;
(d) Any service authorization decision not reached within the timeframes specified in this rule shall constitute a denial and becomes an adverse benefit determination. A notice of action/adverse benefit determination shall be issued on the date the timeframe expires;
(e) MCEs shall give the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested or when reducing a previously authorized service authorization. The notice shall meet the requirements of CFR §438.404 and OAR 410-141-3240;
(f) The MCE and its subcontractors shall have and follow written policies and procedures to ensure consistent application of review criteria for service authorization requests including the following:
(A) MCEs shall consult with the requesting provider for medical services when necessary:
(i) Requesting all the appropriate information to support plan decision making as early in the review process as possible; and
(ii) Adding documentation in the authorization file on outreach methods and dates when additional information was requested from the requesting provider.
(B) Decisions shall be made by an individual who has clinical expertise in addressing the member's medical, behavioral health, or oral needs or in consultation with a health care professional with clinical expertise in treating the member's condition or disease. This applies to decisions to:
(i) Deny a service authorization request;
(ii) Reduce a previously authorized service request; or
(iii) Authorize a service in an amount, duration, or scope that is less than requested.
(C) MCEs shall have written policies and procedures for processing prior authorization requests received from any provider. The policies and procedures shall specify time frames for the following:

(i) Date stamping prior authorization requests when received;
(ii) Determining within a specific number of days from receipt whether a prior authorization request is valid or non-valid;
(iii) The specific number of days allowed for follow-up on pended prior authorization requests to obtain additional information;
(iv) The specific number of days following receipt of the additional information that an approval or denial shall be issued;

(v) Providing services after office hours and on weekends that require prior authorization.
(D) An MCE shall make a determination on at least 95 percent of valid prior authorization requests within two working days of receipt of a prior authorization or reauthorization request related to:
(i) Drugs;
(ii) Alcohol;
(iii) Drug services; or
(iv) Care required while in a skilled nursing facility.
(g) MCEs shall notify providers of an approval, a denial, or the need for further information for all other prior authorization requests within 14 days of receipt of the request as set forth in OAR 410-141-3240 unless otherwise specified in OHP program rules:
(A) MCEs shall make three reasonable attempts using two methods to obtain the necessary information during the 14-day period;
(B) If the MCE needs to extend the timeframe, the MCE shall give the member written notice of the reason for the extension;
(C) The MCE shall make a determination as the member's health or mental health condition requires, but no later than the expiration of the extension.

STATUTORY/OTHER AUTHORITY: 413.042, 414.065, 414.651, 414.615, 414.625, 414.635

STATUTES/OTHER IMPLEMENTED: 414.065, 414.610-414.685

REPEAL: 410-141-3230

RULE TITLE: MCE Grievance and Appeals

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) For purposes of this rule and OAR 410-141-3225 through 410-141-3255 and 42 CFR 438.400 through 438.424, references to member means a member, the member's representative, and the representative of a deceased member's estate.

(2) MCEs shall establish and have an Authority-approved process and written procedures for compliance with grievance and appeals requirements that shall include the following:

(a) Member rights to appeal and request an MCE review of a notice of action/adverse benefit determination, including the ability of providers and authorized representatives to appeal on behalf of a member;

(b) Member rights to request a contested case hearing regarding an MCE notice of action/adverse benefit determination once the plan has issued a written notice of appeal resolution under the Administrative Procedures Act;

(c) Member rights to file a grievance at any time for any matter other than an appeal or contested case hearing;

(d) An explanation of how MCEs shall accept, process, and respond to grievances, appeals, and contested case hearing requests.

(e) Compliance with grievance and appeals requirements as part of state quality strategy and to enforce a consistent response to complaints of violations of consumer rights and protections;

(f) MCEs shall document appeals in an appeals log maintained by the MCE that complies with OAR 410-141-3255 and is consistent with contractual requirements.

(3) The MCE shall provide information to members regarding the following:

(a) An explanation of how MCEs shall accept, process, and respond to grievances, appeals, and contested case hearing requests;

(b) Member rights and responsibilities; and

(c) How to file for a hearing through the state's eligibility hearings unit related to the member's current eligibility with OHP.

(4) The MCE shall adopt and maintain compliance with grievances and appeals process timelines in CFR 42 §438.408(b)(1) and (2) and these rules.

(5) Upon receipt of a grievance or appeal, the MCE shall:

(a) Within five business days, resolve or acknowledge receipt of the grievance or appeal to the member and the member's provider where indicated;

(b) Give the grievance or appeal to staff with the authority to act upon the matter;

(c) Obtain documentation of all relevant facts concerning the issues, including taking into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether the information was submitted or considered in the initial adverse benefit determination or resolution of grievance;

(d) Ensure staff and any consulting experts making decisions on the grievance or appeal are:

(A) Not involved in any previous level of review or decision making nor a subordinate of any such individual;

(B) Health care professionals with appropriate clinical expertise in treating the member's condition or disease, if the grievance or appeal involves clinical issues or if the member requests an expedited review. Health care professionals shall make decisions for the following:

(i) An appeal of a denial that is based on lack of medically appropriate services or involves clinical issues;

(ii) A grievance regarding denial of expedited resolution of an appeal or involves clinical issues.

(C) Taking into account all comments, documents, records, and other information submitted by the member without regard to whether the information was submitted or considered in the initial adverse benefit determination;
(D) Not receiving incentivized compensation for utilization management activities by ensuring that individuals or entities who conduct utilization management activities are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.
(6) The MCE shall analyze all grievances, appeals, and hearings in the context of quality improvement activity pursuant to OAR 410-141-3200 and 410-141-3230.
(7) MCEs shall keep all healthcare information concerning a member's request confidential, consistent with appropriate use or disclosure as defined in 45 CFR 164.501, and include providing member assurance of confidentiality in all written, oral, and posted material in grievance and appeal processes.
(8) The following pertains to the release of a member's information:
(a) The MCE and any provider whose authorizations, treatments, services, items, quality of care, or requests for payment are involved in the grievance, appeal, or hearing may use this information without the member's signed release for purposes of:
(A) Resolving the matter; or
(B) Maintaining the grievance or appeals log as specified in 42 CFR 438.416.
(b) If the MCE needs to communicate with other individuals or entities not listed in subsection (a) to respond to the matter, the MCE shall obtain the member's signed release and retain the release in the member's record.
(9) The MCE shall provide members with any reasonable assistance in completing forms and taking other procedural steps related to filing grievances, appeals, or hearing requests. Reasonable assistance includes but is not limited to:
(a) Assistance from qualified community health workers, qualified peer wellness specialists, or personal health navigators to participate in processes affecting the member's care and services;
(b) Free interpreter services or other services to meet language access requirements where required in 42CFR §438.10;
(c) Providing auxiliary aids and services upon request including but not limited to toll-free phone numbers that have adequate TTY/TTD and interpreter capabilities; and
(d) Reasonable accommodation or policy and procedure modifications as required by any disability of the member.
(10) The MCE, its subcontractors, and its participating providers may not:
(a) Discourage a member from using any aspect of the grievance, appeal, or hearing process or take punitive action against a provider who requests an expedited resolution or supports a member's appeal;
(b) Encourage the withdrawal of a grievance, appeal, or hearing request already filed; or
(c) Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against a member or to request member disenrollment.
(11) In all MCE administrative offices and in those physical, behavioral, and oral health offices where the MCE has delegated responsibilities for appeal, hearing request, or grievance involvement, the MCE shall have the following forms available:
(a) OHP Complaint Form (OHP 3001);
(b) MCE appeal forms;
(c) Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030); or
(d) The Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile.
(12) Adjudication of appeals in a member grievance and appeals process may not be delegated.
(13) In all investigations or requests from the Department of Human Services Governor's Advocacy Office, the Authority's Ombudsman or hearing representatives, the MCE, and participating providers shall cooperate in ensuring access to all activities related to member appeals, hearing requests, and grievances including providing all requested written materials in required timeframes.
(14) If at the member's request the MCE continues or reinstates the member's benefits while the appeal or administrative hearing is pending, the benefits shall continue pending administrative hearing pursuant to OAR 410-141-3250.

(15) If the MCE delegates the grievance and appeal process to a subcontractor, the MCE must:
(a) Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3025 through 410-141-3255;
(b) Monitor the subcontractor's performance on an ongoing basis;
(c) Perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement; and
(d) Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.

STATUTORY/OTHER AUTHORITY: 413.032, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: 414.610-414.685

REPEAL: 410-141-3235

RULE TITLE: MCE Grievance Process Requirements

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) A member may file a grievance at any time either orally or in writing. The grievance may be sent to the MCE or to the Authority. If the grievance is sent to the Authority, it shall be promptly forwarded to the MCE.

(2) For a standard resolution of grievances, the MCE shall resolve each grievance and provide notice of the disposition as expeditiously as the member's health condition requires. The MCE shall:

(a) Within five business days from the date of the MCEs receipt of the grievance, notify the member that a decision on the grievance has been made and what that decisions is; or

(b) Notify the member that there shall be a delay in the MCE's decision of up to 30 days. The written notice shall specify why the additional time is necessary.

(3) The MCE shall ensure that the individuals who make decisions on grievances follow all requirements in OAR 410-141-3230 MCE Grievance and Appeals System General Requirements.

(4) When informing members of the MCE's decision, the MCE:

(a) May provide its decision related to oral grievances either orally or in writing;

(b) Shall address each aspect of the grievance and explain the reason for the decision; and

(c) Shall respond in writing to written grievances. In addition to written responses, the MCE may also respond orally;

(d) Notifies members who are dissatisfied with the disposition of a grievance that they may present their grievance to the Department of Human Services (Department) Client Services Unit or the Authority's Ombudsman.

(5) In compliance with Title VI of the Civil Rights Act and ORS Chapter 659A, the MCE shall review and report to the Authority, as outlined in the CCO contract, complaints that raise issues related to racial or ethnic background, gender identity, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status, and other identity factors for consideration in improving services for health equity.

(6) If an MCE receives a grievance related to a member's entitlement of continuing benefits in the same manner and same amount during the transition of transferring from one MCE to another MCE for reasons defined in OAR 410-141-3080 (15), the MCE shall log the grievance and work with the receiving or sending MCE to ensure continuity of care during the transition.

STATUTORY/OTHER AUTHORITY: 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: 414.610-414.685

REPEAL: 410-141-3240

RULE TITLE: Notice of Action-Adverse Benefit Determination Notice Requirements

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) When an MCE has made an adverse benefit determination, the MCE shall notify the requesting provider and give the member and the member's representative a written notice of action/adverse benefit determination notice. The notice shall:

(a) Comply with the Authority's formatting and readability standards in OAR 410-141-3300 and 42 CFR §438.10 and be written in language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing and following the process for requesting an appeal;

(b) For timing of notices, follow timelines required for the specific service authorization or type via oral and written mechanisms for any service request of the member, the member's authorized representative, or the member's provider outlined in OAR 410-141-3225 MCE Service Authorization or otherwise specified in this rule;

(c) Meet the content notice requirements of 42 CFR §438.404 including but not limited to the following:

(A) Date of the notice;

(B) MCE's name, address, and telephone number;

(C) Name of the member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or behavioral health professional, as applicable;

(D) Member's name, address, and member ID number;

(E) Service requested or previously provided and the adverse benefit determination the MCE made or intends to make, including whether the MCE is denying, terminating, suspending, or reducing a service or denial of payment;

(F) Date of the service or date service was requested by the provider or member;

(G) Name of the provider who performed or requested the service;

(H) Effective date of the adverse benefit determination if different from the date of the notice;

(I) Whether the MCE considered other conditions such as co-morbidity factors if the service was below the funding line on the Prioritized List of Health Services;

(J) Clear and thorough explanation of the specific reasons for the adverse benefit determination, including reference to the specific statutes and administrative rules to the highest level of specificity for each reason and specific circumstance identified in the notice that includes, but is not limited to:

(i) The item requiring prior authorization but not authorized;

(ii) The services or treatment requested not meeting medically necessary or medically appropriate criteria as defined in OAR 410-120-000;

(iii) The service specifically not a covered service or that does not meet requirements based on the Prioritized List of Health Services;

(iv) The service or item received in an emergency care setting that does not qualify as an emergency service;

(v) The person not a member at the time of the service or not a member at the time of the requested service;

(vi) Except in the case of an Indian Health Care Provider (HCP) serving an Indian (AI/AN) member of the CCO, the provider not on the contractor's panel;

(vii) Prior approval not obtained (except as allowed in OAR 410-141-3140); or

(viii) MCE denial of member's disenrollment request and findings that there is no good cause for the request.

(K) Information regarding the member's rights to be provided upon request and at no cost and reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination

including any processes, strategies, or evidentiary standards used by the MCE in setting coverage limits or making the adverse benefit determination;
(L) Information about the member's or the provider's right to file an appeal with the MCE; the right to request a contested case hearing only after the MCE Appeal Notice of Resolution or where the MCE failed to meet appeal timelines as outlined in OAR 410-141-3230; and procedures for exercising these rights in OAR 410-141-3245;
(M) An explanation of circumstances under which the member or the member's provider may request and process for an expedited appeal; and
(N) A statement that the member has the right to request the services that are being denied pending resolution of the appeal and that the member may be responsible for the cost of those services if the outcome of the appeal upholds the MCE's Notice of action.
(d) The Notice shall be on an Authority approved form unless the member is a dually eligible member of affiliated Medicare and Medicaid plans, in which case the CMS Integrated Denial Notice may be used as long as it incorporates required information fields in the Oregon's Notice of Action/Adverse Benefit Determination.
(2) The MCE shall include the appropriate forms based on the Authority-approved Notice of Action/Adverse Benefit Determination as outlined in OAR 410-141-3240. The appropriate forms are:
(a) Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030); or
(b) The Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile.
(3) For requirements of notice of actions/adverse benefit determinations that affect services previously authorized, the MCE shall mail the notice at least ten days before the date the adverse benefit determination reduction, termination, or suspension takes effect, as referenced in 42 CFR 431.211.
(4) In 42 CFR 431.213 and 431.214, exceptions related to advance notice include the following:
(a) The MCE may mail the notice no later than the date of adverse benefit determination if:
(A) The MCE has factual information confirming the death of the member;
(B) The MCE receives a clear written statement signed by the member stating he no longer wishes services or gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;
(C) The MCE can verify that the member has been admitted to an institution where the member is no longer eligible for OHP services from the MCE;
(D) The MCE is unaware of the member's whereabouts and the MCE receives returned mail directed to the member from the post office indicating no forwarding address and the Authority or Department has no other address;
(E) The MCE verifies another state, territory, or commonwealth accepted the member for Medicaid services; or
(F) The member's PCP, PCD, or behavioral health professional prescribed a change in the level of health services.
(b) The MCE must mail the notice five days before the adverse benefit determination when the MCE:
(A) Has facts indicating that an adverse benefit determination should be taken because of probable fraud on part of the member; and
(B) The MCE has verified those facts, whenever possible, through secondary resources.
(c) For denial of payment, the adverse benefit determination shall be mailed at the time of any adverse benefit determination that affects the claim.
(6) Within 60 days from the date on the notice: The member or provider may file an appeal; the member may request a Contested Case Hearing with the Authority after receiving notice that the MCE's adverse benefit determination is upheld; or if the MCE fails to adhere to the notice and timing requirements in 42 CFR 483.408, the Authority may consider the MCE appeals process exhausted.

STATUTORY/OTHER AUTHORITY: 414.615, 414.625, 414.635, 414.651, 414.032

STATUTES/OTHER IMPLEMENTED: 414.610-414.685

REPEAL: 410-141-3245

RULE TITLE: MCE Appeal Requirements

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) A member or a subcontractor or provider with the member's written consent who disagrees with an adverse benefit determination or is contesting the failure of the MCE to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals may file an appeal with the MCE.

(2) Each MCE may have only one level of appeal for members, and members shall complete the appeals process with the MCE prior to requesting a contested case hearing.

(3) For standard resolution of an appeal and notice to the affected parties, the MCE shall establish a timeframe that is no longer than 16 days from the day the MCE receives the appeal:

(a) If an MCE fails to adhere to the notice and timing requirements in 42 CFR §438.408, the member is considered to have exhausted the MCE's appeals process. In this case, the member may initiate a contested case hearing;

(b) The MCE may extend the timeframes from section (3) of this rule by up to 14 days if:

(A) The member requests the extension; or

(B) The MCE shows to the satisfaction of the Authority upon its request that there is need for additional information and how the delay is in the member's interest.

(c) If the MCE extends the timeframes but not at the request of the member, the MCE shall:

(A) Make reasonable efforts to give the member prompt oral notice of the delay;

(B) Within two days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision.

(4) As noted in OAR 410-141-3225 MCE Service Authorization, all notice of actions/adverse benefit determination notices shall provide information on member rights to appeal and request an MCE review of the notice including the ability of providers and authorized representatives to appeal on behalf of a member:

(a) If after filing an oral appeal, a member or the provider on the member's behalf does not submit a written appeal request within the appeal timeframe, the appeal shall expire;

(b) The MCE shall ensure the member is informed that they must file in writing unless the individual filing the appeal requests expedited resolution;

(c) The MCE does not need to notify the member if the MCE has already made attempts to assist the member in filling out the necessary forms to file a written appeal.

(5) For purposes of this rule, an appeal includes a request from the Division to the MCE for review of a notice.

(6) A member or the provider on the member's behalf may request an appeal either orally or in writing directly to the MCE for any notice or failure to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of appeals by the MCE:

(a) The MCE shall ensure oral requests for appeal of a notice are treated as appeals to establish the earliest possible filing date, and unless the member requests an expedited resolution, the member shall follow an oral filing with a written, signed, and dated appeal;

(b) The member shall file the appeal with the MCE no later than 60 days from the date on the notice.

(7) The MCE shall have written policies and procedures for handling appeals that:

(a) Address how the MCE shall accept, process, and respond to appeals, including how the MCE will acknowledge receipt of each appeal;

(b) Ensure members who receive a notice are informed of their right to file an appeal and how to do so as set forth in

OAR 410-141-3245;
(c) Ensure each appeal is transmitted timely to staff having authority to act on it;
(d) Consistent with confidentiality requirements, ensure the MCE's staff designated to receive appeals begins to obtain documentation of the facts concerning the appeal upon receipt;
(e) Ensure each appeal is investigated and resolved in accordance with these rules;
(f) Ensure the individuals who make decisions on appeals follow all requirements in OAR 410-141-3230 MCE Grievance and Appeals System General Requirements;
(g) Document appeals in an appeals log maintained by the MCE that complies with OAR 410-141-3230 MCE Grievance and Appeals System General Requirements and OAR 410-141-3255 Grievance and Appeals System Recordkeeping Requirements, consistent with 42 CFR §438.416;
(h) Provide the member a reasonable opportunity to present evidence and testimony and make legal and factual arguments in person as well as in writing:
(A) The MCE shall inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for standard appeals and in the case of a request for expedited appeals resolution;
(B) The MCE shall provide the member the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCE (or at the direction of the MCE) in connection with the appeal of the adverse benefit determination at no charge and sufficiently in advance of the standard resolution timeframe for appeals.
(8) Parties to the appeal include:
(a) The MCE;
(b) The member and the member's representative, if applicable;
(c) The legal representative of a deceased member's estate.
(9) The MCE shall resolve each standard appeal in the 16 day time period and provide the member and the member's representative with a notice of appeal resolution as expeditiously as the member's health condition requires and within 72 hours for matters that meet expedited appeals reasons.
(10) The member requests the extension or the MCE shows (to the satisfaction of OHA, upon its request) that there is need for additional information and how the delay is in the member's interest. If the MCE extends the timeframes, it shall, for any extension not requested by the member, give the member a written notice of the reason for the delay.
(11) If the MCE or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.
(12) If the MCE or the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the state shall pay for those services in accordance with the Authority policy and regulations.
(13) The written notice of appeal resolution shall be in a format approved by the Authority and include the following information:
(a) The results of the resolution process and the date the MCE completed the resolution; and
(b) For appeals not resolved wholly in favor of the member:
(A) Reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Appeal Resolution relied upon to deny the appeal;
(B) The right to request a contested hearing or expedited hearing with the Authority and how to do so;
(C) The right to request to continue receiving benefits while the hearing is pending and how to do so; and
(D) An explanation that the member may be held liable for the cost of those benefits if the hearing decision upholds the MCE's adverse benefit determination;
(E) The appropriate forms are:
(i) Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030); or

(ii) The Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile.
(14) A member may request a contested case hearing not later than 120 days from the date on the MCE Notice of Appeal Resolution.
(15) If the contested case hearing request was made directly by the member or their representative to the Authority, the MCE shall submit the required documentation to the Authority's Hearings Unit within two business days of the Authority's request.
(16) Required Documentation:
(a) The MCE's records of an appeal shall include, at a minimum, a log of all appeals received by the MCE containing the following information:
(A) Member's name and Medical Care ID number;
(B) Date of the original Notice of Action/Adverse Benefit Determination;
(C) Notice of Appeal Resolution;
(D) Date and nature of the appeal;
(E) Whether continuing benefits were requested and provided; and
(F) Resolution and resolution date of the appeal.
(b) The MCE shall maintain a complete record for each appeal included in the log for no less than 300 days to include:
(A) Records of the review or investigation; and
(B) Resolution including all written decisions and copies of correspondence with the member and all evidence, testimony, or additional documentation provided by the member, the member's representative, or the member's provider as part of the appeal process.

STATUTORY/OTHER AUTHORITY: 413.032

STATUTES/OTHER IMPLEMENTED: 414.065

REPEAL: 410-141-3246

RULE TITLE: Expedited MCE Appeal Requirements

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) Each MCE shall establish and maintain an expedited review process for appeals when the member or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function as set forth in 410-120-1860.

(2) The MCE shall ensure that punitive action is not taken against a provider who requests an expedited resolution.

(3) For expedited resolution of an appeal and notice to affected parties, the MCE shall complete the review of the expedited appeal in a timeframe that is no longer than 72 hours after the MCE receives the appeal. The MCE shall:

(a) Inform the member of the limited time available for receipt of materials or documentation for the review;

(b) Make reasonable efforts to call the member and the provider to tell them of the resolution within 72 hours after receiving the request; and

(c) Mail written confirmation of the resolution to the member within three days;

(d) Extend the timeframes by up to 14 days if:

(A) The member requests the extension; or

(B) The MCE shows (to the satisfaction of the Authority upon its request) that there is need for additional information and how the delay is in the member's interest.

(e) If the MCE extends the timeframes not at the request of the member, the MCE shall:

(A) Make reasonable efforts to give the member prompt oral notice of the delay;

(B) Within two days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.

(4) If the MCE provides an expedited appeal but denies the services or items requested in the expedited appeal, the MCE shall inform the member of the right to request an expedited administrative hearing and send the member an approved Notice of Appeal Resolution, Hearing Request and Information forms as set forth in OAR 410-141-3247.

(5) If the MCE denies a request for expedited resolution on appeal, the MCE shall:

(a) Transfer the appeal to the timeframe for standard resolution in accordance with OAR 410-120-1860;

(b) Make reasonable efforts to give the member and requesting provider prompt oral notice of the denial and follow up within two days with a written notice.

[NOTE: Forms referenced are available from the agency.]

STATUTORY/OTHER AUTHORITY: 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: 414.065

REPEAL: 410-141-3247

RULE TITLE: Contested Case Hearings Requirements

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) An MCE shall have a system in place to ensure its members and providers have access to appeal for MCE's action by requesting a contested case hearing. Contested case hearings are conducted pursuant to ORS 183.411 to 183.497 and the Attorney General's Uniform and Model Rules of Procedure for the Office of Administrative Hearings, OAR 137-003-0501 to 137-003-0700. Processes for contested case hearings are provided in OAR 410-120-1860 Contested Case Hearing Procedures.

(2) The member may not request a hearing without first filing an appeal with their MCE. The member shall file a hearing request using form MSC 0443 with the Authority no later than 120 days from the date of the MCE's notice of appeal resolution. The Authority shall consider the request timely with the exception as noted for expedited hearing requests in OAR 410-141-3248.

(3) A member may request a contested case hearing with the Authority after receiving notice that the MCE notice of action/adverse benefit determination is upheld or, in the case of an MCE that fails to adhere to the notice and timing requirements in 42 CFR §438.408, the Authority may consider that the member has exhausted the MCE's appeals process and may initiate a contested case hearing.

(4) A request for a contested case hearing made prior to MCE appeal by the member or provider shall be forwarded by the Authority to the MCE for review, except in the case where the Authority determines the MCE failed to act within required timelines.

(5) In such cases, the MCE shall receive notice of the Authority's decision to allow the member access to a contested case hearing under the administrative procedures act for failure to adhere to the notice and timing requirements in 42 CFR §438.408.

(6) When a member files a hearing request with the state prior to completion of an MCE appeal or expedited appeal, the Authority shall follow procedures outlined in this rule above.

(7) Effective February 1, 2012, the method described in OAR 137-003-0520(8)–(10) is used in computing any period of time prescribed in OAR chapter 410, divisions 120 and 141 applicable to timely filing of requests for hearing. Due to operational conflicts, the procedures needing revision, and the expense of doing so, OAR 137-003-0520(9) and 137-003-0528(1)(a) that allows hearing requests to be treated as timely based on the date of postmark does not apply to MCE member contested case hearing requests.

(8) If the member files a request for an appeal or hearing with the Authority prior to the member filing with the MCE, the Authority shall transfer the request to the MCE and provide notice of the transfer to the member. The MCE shall:

(a) Review the request immediately as an appeal of the MCE's notice;

(b) Approve or deny the appeal within 16 days and provide the member with a notice of appeal resolution.

(9) If a member sends the contested case hearing request to the MCE after the MCE has already completed the initial plan appeal, the MCE shall:

(a) Date-stamp the hearing request with the date of receipt; and

(b) Submit the following required documentation to the Authority within two business days:

(A) A copy of the hearing request, notice of action/adverse benefit determination, and notice of appeal resolution;

(B) All documents and records the MCE relied upon to take its action, including those used as the basis for the initial action or the notice of appeal resolution, if applicable, and all other relevant documents and records the Authority requests as outlined in detail in OAR 141-410-3245.

(10) A member's provider may request a hearing about an action affecting the provider. The provider shall resolve an appeal with the MCE before requesting a hearing. As stated in OAR 410-141-3245, in addition to the member, a subcontractor or provider with the member's written consent may file an appeal with the MCE if:
(a) There is disagreement with an adverse benefit determination;
(b) The subcontractor or provider is contesting the failure of the MCE to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
(11) The MCE shall approve or deny the appeal within 30 days and provide the subcontractor or provider with a notice of appeal resolution.
(12) The subcontractor or provider appealing for reasons set forth in OAR 410-120-1560 Provider Appeals shall file a hearing request with the Authority no later than 30 days from the date of the MCE's notice of appeal resolution, unless the provider is completing the appeal on behalf of the member, pursuant to OAR 410-120-1560.
(13) The parties to a contested case hearing include the following:
(a) The MCE and the member or the member's representative requesting a hearing; or
(b) The MCE and the member's provider.
(14) The Authority shall refer the hearing request along with the notice of action/adverse benefit determination or notice of appeal resolution to the Office of Administrative Hearings (OAH) for hearing. Contested case hearings are requested using Authority form MSC 443 or other Division-approved appeal or hearing request forms.
(15) The Authority shall issue a final order or the Authority shall resolve the case ordinarily within 90 days from the date the MCE receives the member's request for appeal. This does not include the number of days the member took to subsequently file a contested case hearing request.
(16) For reversed appeal and hearing resolution services:
(a) For services not furnished while the appeal or hearing is pending. If the MCE or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination;
(b) For services furnished while the appeal or hearing is pending. If the MCE or the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the state shall pay for those services in accordance with the Authority policy and regulations.

STATUTORY/OTHER AUTHORITY: 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: 414.610-414.685

REPEAL: 410-141-3248

RULE TITLE: Expedited Contested Case Hearings

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) An MCE shall have a system in place to ensure its members and providers have access to expedited review for MCE's action by requesting an expedited contested case hearing. Contested case hearings are conducted pursuant to ORS 183.411 to 183.497 and the Attorney General's Uniform and Model Rules of Procedure for the Office of Administrative Hearings, OAR 137-003-0501 to 137-003-0700. Processes for expedited contested case hearings are provided in OAR 410-120-1860 Contested Case Hearing Procedures.

(2) A member or provider who believes that taking the time for a standard resolution of a request for a contested case hearing could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function may request an expedited contested case hearing.

(3) The member may not request an expedited contested case hearing without first filing an appeal or expedited appeal with the MCE. When a member files a hearing request prior to completion of an MCE appeal or expedited appeal, the Authority shall follow procedures set forth in OAR 410-141-3247.

(4) Expedited hearings are requested using Authority form MSC 443 or other Division approved appeal or hearing request forms.

(5) The MCE shall submit relevant documentation to the Authority within two working days of any decision of an expedited appeal. The Authority shall decide within two working days from the date of receiving the medical documentation applicable to the request whether the member is entitled to an expedited contested case hearing.

(6) If the Authority denies a request for an expedited contested case hearing, the Authority shall:

(a) Handle the request for a contested case hearing in accordance with OAR 410-120-1860; and

(b) Make reasonable efforts to give the member prompt oral notice of the denial and follow up within two days with a written notice.

(7) If a member requests an expedited hearing, the Authority shall request documentation from the MCE, and the MCE shall submit relevant documentation including clinical documentation to the Authority within two working days.

STATUTORY/OTHER AUTHORITY: 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: 414.610-414.685

REPEAL: 410-141-3250

RULE TITLE: Continuation of Benefits

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) A member who may be entitled to continuing benefits may request and receive continuing benefits in the same manner and same amount while an appeal or contested case hearing is pending:

(a) To be entitled to continuing benefits, the member shall complete an MCE appeal request or an Authority contested case hearing request for continuing benefits no later than:

(A) The tenth day following the date of the notice of action/adverse benefit determination or the notice of appeal resolution; and

(B) The effective date of the action proposed in the notice, if applicable.

(b) In determining timeliness, delay for good cause as defined in OAR 137-002-0528 is not counted;

(c) The benefits shall continue until:

(A) Unless the member requests a contested case hearing with continuing benefits, no later than ten days following the date of the MCE notice of appeal resolution, a final appeal resolution resolves the MCE appeal;

(B) A final order resolves the contested case;

(C) The time period or service limits of a previously authorized service have been met; or

(D) The member withdraws the request for a hearing.

(2) For reversed appeal and hearing resolution services:

(a) Not furnished while the appeal or hearing is pending. If the MCE or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination;

(b) Furnished while the appeal or hearing is pending. If the MCE or the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the Authority shall pay for those services in accordance with the Authority policy and regulations.

STATUTORY/OTHER AUTHORITY: 413.032, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: 414.610-414.685

REPEAL: 410-141-3255

RULE TITLE: Grievance and Appeals System Recordkeeping

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) Each MCE shall maintain records of grievances and appeals and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the state quality strategy as stated in 42 CFR 438.416 and in alignment with contractual requirements.

(2) MCE's must maintain yearly logs of all appeals and grievances for ten years with the following requirements:

(a) The logs must contain the following information pertaining to each member's appeal or grievance:

(A) The member's name, ID number, and date the member filed the grievance or appeal;

(B) Documentation of the MCE's review, resolution or disposition of the matter, including the reason for the decision and the date of the resolution or disposition;

(C) Notations of oral and written communications with the member; and

(D) Notations about appeals and grievances the member decides to resolve in another way if the MCE is aware of this;

(E) The log must contain a general description of the reason for an appeal.

(b) For each year, the logs must contain the following aggregate information:

(A) The number of actions; and

(B) A categorization of the reasons for and resolutions or dispositions of appeals and grievances.

(3) The MCE must review the log monthly for completeness and accuracy, which includes but is not limited to timeliness of documentation and compliance with procedures.

(4) MCES shall submit to the Authority's Contract Administration Unit, with the Grievance and Appeals Log, samples of Notices of Adverse Benefit Determination. The recommended sample size is twenty per quarter per MCE.

(5) The MCE shall submit, 45 days following the end of each quarter, a Grievance System Report in a format and to a location acceptable to the Authority and identified in the MCE contract.

(6) The MCE shall incorporate data collected from monitoring of its grievance system to analyze its Grievance System, including all grievances and appeals data reported by the MCE in the Grievance and Appeal Log.

(7) The analysis of the Grievance System shall demonstrate how the MCE uses data collected by the MCE, its sub-delegates, and its providers to maintain an effective process for monitoring, evaluating, and improving the access, quality, and appropriateness of services provided to members. The MCE shall address all sections in the Grievance System Report template provided by The Authority.

(8) The Grievance System Report and Grievance and Appeals Log shall be forwarded to the MCE's Quality Improvement committee to comply with the Quality Improvement standards as follows:

(a) Review of completeness, accuracy, and timeliness of documentation;

(b) Compliance with written procedures for receipt, disposition, and documentation; and

(c) Compliance with applicable OHP rules.

STATUTORY/OTHER AUTHORITY: 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: 414.610-414.685

REPEAL: 410-141-3258

RULE TITLE: Contract Termination and Close-Out Requirements

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) This rule applies to any termination of an MCE contract, including but not limited to non-renewal under OAR 410-141-3041, expiration of the contract at the end of its term, or termination during the term of the contract initiated by either party. Consistent with OAR 410-141-3041, MCEs shall abide by all requirements in this rule regardless of whether termination notice is provided by the Authority or the MCE.

(2) The party initiating the termination shall render written notice of termination to the other party by certified mail, return receipt requested, or in person with proof of delivery and a contemporaneous copy emailed to the other party's contract administrator.

(3) The notice of termination shall specify the circumstances giving rise to termination and the date on which such termination shall become effective.

(4) After receipt of an MCE's notification of intent not to renew or notice of termination, the Authority shall issue written notice to the MCE specifying:

(a) The effective date of termination;

(b) The MCE's operational and reporting requirements; and

(c) Timelines for submission of deliverables.

(5) Upon notification of termination or non-renewal, an MCE shall submit to the Authority a transition plan detailing how it fulfills its continuing obligations for the duration of the contract. The transition plan shall include:

(a) How each of the MCE's members and contracted providers are notified of the termination of the contract;

(b) A plan to transition its members to other MCEs; and

(c) A plan for closing out its MCE business, including but not limited to the operational and reporting requirements and timelines for submission of deliverables, as specified by the Authority, and the requirements specified in this rule.

(6) Transition plans are subject to approval by the Authority:

(a) The MCE must revise the transition plan as necessary to obtain approval by the Authority;

(b) Failure to submit a transition plan and obtain written approval of the termination plan by the Authority may result in the Authority's withholding of 20 percent of the MCE's monthly capitation payment until the Authority has approved the transition plan;

(c) If the Authority's approval of the transition plan occurs less than 90 days before the effective date of termination, then the Authority may require the MCE to extend the contract to a later effective date of termination, including as necessary the MCE's acceptance of amendments to the contract generally applicable to MCE contracts through the extended effective date.

(7) The MCE shall designate an individual as the contract transition coordinator.

(8) The contract transition coordinator shall be the Authority's contact for ensuring the MCE's completion of the MCE's contractual obligations, performance, operations, and member transitions including the transition plan.

(9) MCEs must submit reports to the Authority every30 calendar days detailing the MCE's progress in executing its transition plan. In the event of the MCE's substantial failure to execute timely its transition plan, the Authority may withhold 20 percent of any payments due to the MCE from the Authority until such failure is corrected.

(10) MCEs shall submit a final report to the Authority describing how it fulfilled all transition and close-out activities described in the transition plan. The final report is subject to the Authority approval before issuance of any final payment.

(11) MCEs shall continue to perform all financial, management, and administrative services obligations identified in contract throughout the closeout period, including at minimum:
(a) Restricted reserves and insurance coverage for a period of 18 months following the notice of termination, or until the state provides the MCE with written release agreeing that all continuing obligations are fulfilled, whichever is earlier;
(b) Maintaining adequate staffing to perform all required functions as specified in contract;
(c) Supplying all information necessary to the Authority or its designee upon request for reimbursement of any outstanding claims at the time of termination;
(d) Assisting the Authority to ensure an orderly transition of member services after notice of termination consistent with the Authority's Transition of Care Policy; and
(e) To make available all signed provider agreements or subcontracts to the Authority upon request.
(12) The MCE must arrange for the orderly transfer of all OHP members assigned to the MCE to coverage under any new arrangement authorized by the Authority, including any actions required by the Authority to complete the transition of members and the termination of the MCE contract. These actions include:
(a) Forwarding of all medical or financial records related to the contractually obligated activities;
(b) High needs care coordination;
(c) Facilitation and scheduling of medically necessary appointments for care and services;
(d) Identification of chronically ill, high risk, hospitalized, and pregnant members in their last four weeks of pregnancy.
(13) If a change of providers may be harmful to the member, the MCE must continue to provide services until that treatment is concluded or appropriate transfer of care is arranged.
(14) The MCE shall make available and require its providers and subcontractors to make available to the Authority copies of medical, behavioral, oral and managed long-term services and supports records, patient files, and any other pertinent information necessary for efficient care management of enrollees, as determined by the Director of the Authority:
(a) Records shall be in a usable form and shall be provided at no expense to the Authority, using a file format and dates for transfer specified by the Authority;
(b) Under no circumstances shall a Medicaid member be billed for this service;
(c) Information that shall be required includes:
(A) Numbers and status of grievances in process;
(B) Numbers and status of hospital authorizations in process, listed by hospital;
(C) Daily hospital logs;
(D) Prior authorizations approved, pending, or denied;
(E) Program exceptions approved;
(F) Medical cost ratio data;
(G) Information on outstanding payments for medical care rendered to members;
(H) All encounter data required under the terminated agreement;
(I) Identification of members whose treatment or treatment plans require continuity of care consideration;
(J) Any other information or records deemed necessary by the Authority to facilitate the transition of care.
(15) Following expiration of the contract and the completion of closeout period obligations, the MCE shall:
(a) Maintain claims processing functions as necessary for a minimum of 18 months after the date of termination. If additional claims are outstanding, the MCE shall maintain the claims processing system as long as necessary to complete final adjudication of all claims;
(b) Remain liable and retain financial responsibility for all claims with dates of service prior to the date of termination;
(c) Maintain financial responsibility for patients who are hospitalized prior to the termination date through the date of discharge or for patients receiving post hospital extended care benefits after termination to the extent the MCE is responsible under the contract;
(d) Maintain financial responsibility for services rendered prior to the termination date, for which payment is denied by

the MCE and subsequently approved upon appeal by the provider; and
(e) Assist the Authority with grievances and appeals for dates of service prior to the termination date.
(16) Runout activities shall consist of the processing, payment, and reconciliations necessary regarding all enrollees, claims for payment from providers, appeals by both providers and members, and financial reporting deemed necessary by the Authority, including:
(a) Monthly claims aging report including IBNR amounts;
(b) Quarterly financial statements and annual audited financial statements in conformity with the specification in the contract up to the date specified by the Authority;
(c) Certified encounter reporting until all services rendered prior to contract expiration or termination have reached adjudicated status and the Authority data validation of the information is complete;
(d) Arranging for the retention, preservation, and availability of all records, including those records related to member grievance and appeals, litigation, base data, Medical Loss Ratio (MLR) reports, claims settlement, and those records covered under HIPAA as required by contract and state and federal law;
(e) Details of any existing third-party liability (TPL) or personal injury lien (PIL) cases and making any necessary arrangements to transfer the cases to the Authority's TPL and PIL units; and
(f) Final reports that identify all expenditures for any period in which the MCE continued to pay claims for services provided during the contract period.
(17) The Authority may require status reports or updates to the data reporting requirements in section (16) upon request.
(18) MCEs shall submit to the Authority a written request for release certifying that all obligations have been satisfied. The Authority shall provide an official written release upon satisfaction of activities associated with the contract expiration or termination plan. The request must be signed, expressly under penalty of False Claims Act liability, by the president and the chief financial officer of the MCE and must attest that, except as expressly described in a writing attached to the attestation:
(a) All payments are received by the MCE under the contract, and all the MCE's liabilities under the contract are extinguished;
(b) All reports, reconciliations, member matters, and provider matters are resolved and finalized; and
(c) The MCE complied with all contractual and legal requirements, including completion of the activities described in the transition plan.
(19) To the extent that the request for release under section (18) attaches any exception, the request for release must include a plan describing how each exception is resolved. Any payments due under the terms of the contract for services between the Authority and the MCE, including the distribution of restricted reserve funds or any withheld capitation amount, may be withheld until the Authority receives all written and properly executed documents from the MCE. The MCE is subject to all obligations under the contract, associated rules, and the transition plan until a final written release is issued by the Director of the Authority. Such release:
(a) Shall apply only to the extent of the MCE's responsibilities under the MCE contract, associated rules, and the transition plan;
(b) Shall apply only to the extent the MCE's submissions to the Authority are true, complete, and accurate;
(c) Shall apply only between the Authority and the MCE;
(d) May not bind third parties;
(e) May not preclude the Authority's assertion of indemnity, contribution, or other obligations based on third-party claims;
(f) May not preclude the Authority's assertion of false claims liability, Medicaid fraud, common-law fraud, or other claims, false statements, or fraud; and
(g) May not affect any post-termination obligations of the MCE under the contract for preservation of records or for auditors' access.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

REPEAL: 410-141-3259

RULE TITLE: Sanctions

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) The Authority may establish and impose sanctions on CCOs, pursuant to 42 CFR § 438.700, if the Authority makes a determination specified in paragraph (3) of this rule.

(2) The Authority may base its determinations on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

(3) The Authority may impose sanctions if the Authority determines that an MCE acts or fails to act as follows:

(a) Fails substantially to provide medically necessary services required under law or under its contract with the Authority to an enrollee covered under the contract;

(b) Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;

(c) Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to re-enroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services;

(d) Misrepresents or falsifies information that it furnishes to the Centers for Medicare and Medicaid Services (CMS) or to the state;

(e) Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider;

(f) Fails to comply with the requirements for physician incentive plans, as set forth in 42 CFR §§ 422.208 and 422.210;

(g) Distributes directly or indirectly through any agent or independent contractor marketing materials that are not approved by the Authority or that contain false or materially misleading information;

(h) Violates any of the other applicable requirements of state or federal Medicaid law.

(4) The Authority may impose a range of sanctions under this rule including the following:

(a) Civil monetary penalties in the amounts specified in section (5) of this rule;

(b) Appointment of temporary management for an MCE as permitted under 42 CFR 438.706;

(c) Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll;

(d) Suspension of all new enrollment, including default enrollment, after the date the Authority notifies the MCE of a determination of a violation of rule or contract requirements;

(e) Suspension of payment for members enrolled after the effective date of the sanction and until the Authority is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur;

(f) Additional sanctions available under Oregon Revised Statutes and Oregon Administrative Rules that address areas of noncompliance specified in section (3) of this rule or any additional areas of noncompliance.

(5) If the Authority imposes civil monetary penalties:

(a) The maximum civil monetary penalty the Authority may impose varies depending on the nature of the MCE's action or failure to act, subject to the limits in 42 CFR § 422.204(b) and (c);

(b) The Authority may issue penalties as specified on a per event, per member impacted, or per day basis for the duration of noncompliance.

(6) Before imposing any sanctions, the Authority must give the affected MCE timely written notice that explains the following:

(a) The basis and nature of the sanction;
(b) Any appeal rights under this rule and any other appeal rights that the Authority elects to provide.
(7) Administrative review, and if requested mediation:
(a) Are available for review of sanction decisions in accordance with OAR 410-120-1580 and 410-141-3267;
(b) If the Authority determines that there is continued egregious behavior, or that such action is necessary to ensure the health or safety of members, the Authority may impose the sanction before an administrative review opportunity is provided.
(8) Before terminating an MCE's contract for cause, the Authority must provide the MCE the opportunity for a pre-termination hearing. The Authority must do all of the following:
(a) Give the MCE written notice of its intent to terminate, the reason for termination, and the time and place of the hearing;
(b) After the hearing, give the MCE written notice of the decision affirming or reversing the proposed termination of the contract and for an affirming decision the effective date of termination;
(c) For an affirming decision, give enrollees of the MCE notice of the termination and information on their options for receiving Medicaid services following the effective date of termination.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

REPEAL: 410-141-3267

RULE TITLE: Process for Resolving Disputes between Coordinated Care Organizations (CCOs) and the Oregon Health Authority

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) If a CCO has a dispute with the Oregon Health Authority (Authority) as a result of a Division of Medical Assistance Programs (Division) decision that is perceived as adversely affecting a CCO, the CCO may submit a request to the Division director or his or her designee requesting an Administrative Review, as prescribed in OAR 410-120-1580.

(2) An example of such disputes include, but is not limited to, Authority decisions made through the OHA Provider Discrimination Review Process as a result of a provider discrimination appeal. These disputes primarily address legal or policy issues that may arise in the context of a Division decision that is perceived by the CCO to adversely affect the CCO and is not otherwise reviewed as a claim redetermination, a contested case, or client appeal. This rule does not involve claims that the Authority has breached its contract with a CCO. This CCO process is not mandatory, and it need not be exhausted before a CCO seeks judicial review or brings any other form of action related to any CCO/Authority dispute related decision.

(3) Within thirty calendar days of the conclusion of the administrative review, or such other time as may be agreed to by the CCO and the Division, the Division shall send written results of the administrative review to the initiating CCO and any other affected CCO. Should a resolution be reached through administrative review that is mutually agreeable to all involved, the process shall be considered complete and binding.

(4) If the dispute between the CCO and the Authority remains unresolved as a result of the administrative review, the CCO may request an alternative dispute resolution as set forth in section (5) of this rule to attempt to resolve the issue. The alternative dispute process is conducted pursuant to the Attorney General's Uniform Model Rules OAR 137-005-0060 and 137-005-0070.

(5) Not more than ten business days after receipt of the final administrative review decision, the CCO may contact the Division director indicating the CCO's intent to pursue mediation. In that request, the CCO may request to stay the administrative review decision, which the Division will grant if the CCO alleges sufficient facts and provides good cause for the stay as provided in OAR 137-004-0090.The Division shall respond within ten business days of the date of the stay request

(6) After both the CCO and the Authority agree to enter into mediation, both shall attempt to agree on the selection of the mediator and complete paperwork required to secure the mediator's services. If the CCO and the Authority are unable to agree on the selection of a mediator, both shall appoint a mediator, and those mediators shall select the final mediator. To be qualified to propose resolutions for disputes under this rule, the mediator shall:

(a) Be a knowledgeable and experienced mediator;

(b) Be familiar with health care and the disputed matters; and

(c) Follow the terms and conditions specified in this rule for the mediation process.

(7) If the dispute is likely to impact another CCO, the Authority shall notify all CCOs potentially impacted by the dispute and provide an opportunity for the impacted CCOs to participate in the dispute resolution process.

(8) The CCO and the Authority shall share in the cost of all mediation expenses, whether the dispute is resolved or not.

(9) Within ten business days of a selection of a mediator or upon a different schedule, as agreed to by the parties and the mediator, the CCO and the Authority shall submit to each other and to the mediator the following:

(a) Dispute resolution offer; and

(b) Explanation of their position, i.e., advocacy brief.

(10) The parties will engage in mediation as arranged by the mediator.

(11) The Authority shall maintain the confidentiality of proprietary information of all participating CCOs to the extent the information is protected under state or federal law.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 183.484, 183.502, 413.042

REPEAL: 410-141-3268

REPEAL: Temporary 410-141-3268 from DMAP 29-2019

RULE TITLE: Process for Resolving Disputes on Formation, Certification, and Recertification of CCOs

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) The dispute resolution process described in this rule applies only when, under ORS 414.635:

(a) An entity is applying to the Authority for certification as a CCO (applicant);

(b) A Health Care Entity (HCE) and the applicant (together, the "parties" for purposes of this rule) have failed to agree upon terms for a contract; and

(c) One or more of the following occurs:

(A) The applicant states that the HCE is necessary for the applicant to qualify as a CCO;

(B) An HCE states that its inclusion is necessary for the applicant to be certified as a CCO; or

(C) In reviewing the applicant's information, the Authority identifies the HCE as necessary for the applicant to qualify as a CCO.

(2) If an applicant and HCE disagree about whether the HCE is necessary for the applicant's certification as a CCO, the applicant or HCE may request the Authority to review the issue.

(3) If the Authority determines the HCE is not necessary for the applicant's certification, the process described in this rule does not apply.

(4) If the Authority determines or the parties agree the HCE is necessary for the applicant's certification, the following applies:

(a) The HCE and the applicant shall participate in good faith contract negotiations. The parties shall take the following actions in an attempt to reach a good faith resolution:

(A) The applicant shall provide a written offer of terms and conditions to the HCE. The HCE shall explain the area of disagreement to the applicant;

(B) The applicant's or HCE's chief financial officer, chief executive officer, or an individual authorized to make decisions on behalf of the HCE or applicant shall have at least one face-to-face meeting in a good faith effort to resolve the disagreement.

(b) The applicant or HCE may request the Authority to provide technical assistance. The Authority also may offer technical assistance, with or without a request. The Authority's technical assistance is limited to clarifying the CCO certification process, criteria, and other program requirements.

(5) Pursuant to 2013 Engrossed SB 568 and 2013 Oregon Laws chapter 27, if the applicant and HCE cannot reach agreement on contract terms within ten calendar days of the face-to-face meeting, either party may request arbitration. The requesting party shall notify the other party in writing to initiate a referral to an independent third party arbitrator for an HCE's refusal to contract with the CCO or the termination, extension, or renewal of a HCE's contract with a CCO. The party initiating the referral shall provide a copy of the notification to the Authority.

(6) After notification that one party initiated arbitration, the parties shall attempt to agree upon the selection of the arbitrator and complete the paperwork required to secure the arbitrator's services. If the parties are unable to agree, each party shall appoint an arbitrator, and these arbitrators shall select the final arbitrator.

(7) The parties shall pay for all arbitration costs. In consideration of potentially varied financial resources between the parties, which may pose a barrier to the use of this process, the parties may ask the arbitrator to allocate costs between the parties based on ability to pay.

(8) Within ten calendar days of a referral to an arbitrator, the applicant and HCE shall submit to each other and to the

arbitrator the following:
(a) The most reasonable contract offer; or
(b) The HCE's statement that a contract is not desirable and an explanation of why this is reasonable.
(9) Within ten calendar days of receiving the other party's offer or the HCE's statement that a contract is not desirable, each party shall submit to the arbitrator and the other party the advocacy briefs regarding whether the HCE is reasonably or unreasonably refusing to contract with the applicant.
(10) The arbitrator shall apply the following standards when making a determination about whether an HCE reasonably or unreasonably refused to contract with the applicant:
(a) An HCE may reasonably refuse to contract when an applicant's reimbursement to an HCE for a health service is below the reasonable cost to provide the service. The arbitrator shall apply federal or state statutes or regulations that establish specific reimbursements, such as payments to federally qualified health centers, rural health centers, and tribal health centers; and
(b) An HCE may reasonably refuse to contract if that refusal is justified in fact or by circumstances, taking into consideration the Health Services Transformation (HST) legislative policies. Facts or circumstances outlining what is a reasonable or unreasonable refusal to contract include, but are not limited to:
(A) Whether contracting with the applicant would impose demands that the HCE cannot reasonably meet without significant negative impact on HCE costs, obligations, or structure while considering the proposed reimbursement arrangement or other CCO requirements. Some of the requirements include:
(i) Use of electronic health records;
(ii) Service delivery requirements, or
(iii) Quality or performance requirements;
(B) Whether the HCE's refusal affects access to covered services in the applicant's community. This factor alone cannot result in a finding that the refusal to contract is unreasonable; however, the HCE and applicant shall make a good faith effort to work out differences in order to achieve beneficial community objectives and HST policy objectives;
(C) Whether the HCE has entered into a binding obligation to participate in the network of a different CCO or applicant and that participation significantly reduces the HCE's capacity to contract with the applicant.
(11) The following outlines the arbitrator determination and the parties' final opportunity to settle:
(a) The arbitrator shall evaluate the final offers or statement of refusal to contract and the advocacy briefs from each party and issue a determination within 15 calendar days of the receipt of the parties' information;
(b) The arbitrator shall provide the determination to the parties. The arbitrator and the parties may not disclose the determination to the Authority for ten calendar days to allow the parties an opportunity to resolve the issue themselves. If the parties resolve the issue no later than the end of the tenth day, the arbitrator may not release the determination to the Authority;
(c) If the parties have not reached an agreement after ten calendar days, the arbitrator shall provide its decision to the Authority. After submission to the Authority, the arbitrator's determination becomes a public record, subject to protection of trade secret information if identified by one of the parties prior to the arbitrator's submission of the determination.
(12) If the parties cannot agree, the Authority shall evaluate the arbitrator's determination and may take the following actions:
(a) The Authority may certify an applicant if the arbitrator determined the applicant made a reasonable attempt to contract with the HCE or the HCE's refusal to contract was unreasonable;
(b) The Authority may refuse to certify, recertify, or continue to certify an applicant when the arbitrator determined the applicant did not reasonably attempt to contract with the HCE or the HCE's refusal to contract was reasonable, and the Authority determines that participation from the HCE remains necessary for certification of applicant as a CCO;
(c) The Authority may not pay fee-for-service reimbursements to an HCE if the arbitrator determined the HCE unreasonably refused to contract with the applicant. This applies to health services available through a CCO;
(d) In any circumstance within the scope of this rule when the parties have failed to agree, the current statutes regarding

reimbursement to non-participating providers shall apply to certified CCOs and the HCE, consistent with ORS 414.743 for hospitals and consistent with Authority rules for other providers.

(13) To be qualified to resolve disputes under this rule, the arbitrator shall:

(a) Be a knowledgeable and experienced arbitrator;

(b) Be familiar with health care provider contracting matters;

(c) Be familiar with HST; and

(d) Follow the terms and conditions specified in this rule for the arbitration process.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3269

RULE TITLE: Process for Resolving Contract Disputes Between Health Care Entities and Coordinated Care Organizations

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) Pursuant to ORS 414.635, Coordinated Care Organizations (CCOs) and Health Care Entities (HCE) shall participate in good faith contract negotiations. This rule covers the termination, extension, and renewal of an HCE's contract with a CCO.

(2) In the event of a dispute involving the termination, extension, or renewal of an HCE's contract with a CCO, the parties may take the following actions in an attempt to reach a good faith resolution:

(a) Both parties shall provide a written offer of terms and conditions to the other party. The parties shall explain the basis for their disagreement with the terms and conditions offered by the other party;

(b) The CCO's and HCE's chief financial officer, chief executive officer, or an individual authorized to make decisions on behalf of the HCE or CCO shall have at least one face-to-face meeting in a good faith effort to resolve the disagreement;

(c) The CCO or HCE may request the Authority to provide technical assistance. The Authority's technical assistance is limited to clarifying the CCO contractual provisions, subcontracting criteria, current reimbursement requirements, access standards, and other legal requirements.

(3) If the CCO and HCE cannot reach agreement on contract terms, the parties may engage in mediation. Either the CCO or the HCE may request mediation:

(a) After the parties have agreed to enter into mediation, the parties shall attempt to agree on the selection of the mediator and complete paperwork required to secure the mediator's services. If the parties are unable to agree, each party shall appoint a mediator, and those mediators shall select the final mediator;

(b) To be qualified to propose resolutions for disputes under this rule, the mediator shall:

(A) Be a knowledgeable and experienced mediator;

(B) Be familiar with health care and contracting matters; and

(C) Follow the terms and conditions specified in this rule for the mediation process.

(c) The parties shall pay for all mediation costs, whether a conclusion is reached or not. In consideration of potentially varied financial resources between the parties, which may pose a barrier to the use of this process, the parties may ask the mediator to allocate costs between the parties based on the ability to pay;

(d) Within ten business days of a selection of a mediator, the CCO and HCE shall submit to each other and to the mediator the following:

(A) Contract offer; and

(B) Explanation of their position (i.e., advocacy brief).

(e) Unless an extension is agreed on by all parties, the mediator shall issue a report to the involved parties that will include mediation findings and recommendations no longer than 15 business days from the conclusion of the mediation.

(4) Pursuant to ORS 414.635, if the CCO and HCE cannot reach an agreement on contract terms within ten business days of receipt of the mediator's report, either party may request non-binding arbitration. The requesting party shall notify the other party in writing of the party's intent to refer the matter to arbitration:

(a) After notification that one party initiated arbitration, the parties shall agree on the selection of the arbitrator and complete the paperwork required to secure the arbitrator's services. If the parties are unable to agree, each party shall appoint an arbitrator, and these arbitrators shall select the final arbitrator;

(b) To be qualified to propose resolutions for disputes under this rule, the arbitrator shall:

(A) Be a knowledgeable and experienced arbitrator;
(B) Be familiar with health care provider contracting matters; and
(C) Follow the terms and conditions specified in this rule for the arbitration process.
(c) The parties shall pay for all arbitration costs. In consideration of potentially varied financial resources between the parties, which may pose a barrier to the use of this process, the parties may ask the arbitrator to allocate costs between the parties based on ability to pay;
(d) Within ten business days of a selection of an arbitrator, the CCO and HCE shall submit to each other and to the arbitrator the following:
(A) Final contract offer; and
(B) Explanation of their position (i.e., advocacy brief).
(e) The arbitrator shall evaluate the final offers and the advocacy briefs from each party and issue a non-binding determination within 15 business days of the receipt of the parties' submissions.

STATUTORY/OTHER AUTHORITY: ORS 414.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3270

RULE TITLE: Coordinated Care Organization Marketing Requirements

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) For the purposes of this rule, the following definitions apply:

(a) "Cold-call Marketing" means any unsolicited personal contact with a potential member for the purpose of marketing by the CCO.

(b) "Marketing" means any communication from a CCO to a potential member who is not enrolled in the CCO that can reasonably be interpreted as intended to compel or entice the potential member to enroll in that particular CCO.

(c) "Marketing Materials" means materials that are produced in any medium by or on behalf of a CCO and that can reasonably be interpreted as intended to market to potential members.

(d) "Outreach" means any communication from a CCO to any audience that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular CCO. Outreach activities include, but are not limited to, the act of raising the awareness of the CCO, the CCO's subcontractors and partners, and the CCO contractually required programs and services; and the promotion of healthful behaviors, health education and health related events.

(e) "Outreach Materials" means materials that are produced in any medium, by or on behalf of a CCO that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular CCO.

(f) "Potential Member" means a person who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific CCO.

(2) CCOs shall comply with 42 CFR 438.10, 438.100 and 438.104 to ensure that before enrolling OHP clients, the CCO provides accurate oral and written information that potential members need to make an informed decision on whether to enroll in that CCO. CCOs shall distribute the materials to its entire service area as indicated in its CCO contract. The CCOs may not:

(a) Distribute any marketing materials without first obtaining state approval;

(b) Seek to compel or entice enrollment in conjunction with the sale of or offering of any private insurance; and

(c) Directly or indirectly engage in door to door, telephone, or cold-call marketing activities.

(3) The following communications are expressly permitted:

(a) The creation of name recognition and communication methodologies may include, but are not limited to, brochures, pamphlets, newsletters, posters, fliers, websites, bus wraps, bill boards, web banners, health fairs, or health related events.

(b) A CCO or its subcontractor's communications that express participation in or support for a CCO by its founding organizations or its subcontractors may not constitute an attempt to compel or entice a client's enrollment.

(4) CCOs shall update plan access information with the Authority on a monthly basis for use in updating the availability charts. The Authority shall confirm information before posting.

(5) CCOs have sole accountability for producing or distributing materials following Authority approval.

(6) CCOs shall comply with the Authority marketing materials submission guidelines. CCOs shall participate in development of guidelines with the Authority through a transparent public process, including stakeholder input. The guidelines include, but are not limited to:

(a) A list of communication or outreach materials subject to review by the Authority;

(b) A clear explanation of the Authority's process for review and approval of marketing materials;

(c) A process for appeals of the Authority's edits or denials;

(d) A marketing materials submission form to ensure compliance with CCO marketing rules; and

(e) An update of plan availability information submitted to the Authority on a monthly basis for review and posting.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3280

RULE TITLE: Managed Care Entity (MCE) Potential Member Information Requirements

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) Information for potential members shall comply with marketing prohibitions in 42 CFR 438.104 and OAR 410-141-3270 Oregon Health Plan Marketing Requirements.

(2) The creation of name recognition because of the MCE health promotion or education activities may not constitute an attempt by the MCE to influence a client's enrollment.

(3) An MCE or its subcontractor's communications that express participation in or support for an MCE by its founding organizations or its subcontractors may not constitute an attempt to compel or entice a client's enrollment.

(4) The following may not constitute marketing or an attempt by the MCE to influence client enrollment:

(a) Communications to notify dual-eligible members of opportunities to align MCE provided benefits with Medicare Advantage or Special Needs Plans;

(b) Improving coordination of care;

(c) Communicating with providers serving dual-eligible members about unique care coordination needs; or

(d) Streamlining communications to the dually-enrolled member to improve coordination of benefits.

(5) MCEs shall update plan access information with the Authority on a monthly basis for use in updating the availability charts. The Authority shall confirm the information before the MCE may post.

(6) MCEs shall develop informational materials for potential members.

(7) MCEs shall provide the Authority with informational materials sufficient for the potential member to make an informed decision about provider selection. The MCE shall make available to potential members, upon request, information on participating providers.

(8) MCE provider directories for potential members shall include all specified elements and be made readily accessible as noted in OAR 410-141-3300. An MCE or the Authority may include informational materials in the application packet for potential members.

(9) MCEs shall include information for potential members stating that Indians (AI/AN) enrolled in the MCEs may select an Indian health care provider (IHCP) that is participating as a primary care provider within the network of the MCE, insofar as the individual is otherwise eligible to receive primary care services from such Indian health care provider (IHCP) and the Indian health care provider has the capacity to provide primary care services to such Indian.

(10) MCEs shall clearly explain to potential members that Indians enrolled in an MCE shall also be permitted to obtain primary care services covered under the contract between the state and MCE from out-of-network IHCPs from whom the enrollee is otherwise eligible to receive primary care services. Prior authorization to receive services from an IHCP may not be permitted solely based on criteria that the provider is an IHCP or out of network, and Indians may be referred by out-of-network IHCPs to a network provider without prior authorization or referral from a participating provider.

(11) MCEs shall develop informational materials for potential members in their service area that meet the language requirements as identified in this rule. Materials shall be culturally and linguistically appropriate and be sensitive to people with disabilities or reading limitations, including those whose primary language is not English.

(12) MCE's shall honor requests made by other sources such as potential members, potential family members, or caregivers for language accommodation, translating to the potential member's language needs as requested. Alternate formats shall be provided and may include but are not limited to braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language

interpretation and sighted guide:
(a) MCEs shall address health literacy issues by preparing these documents at a 6th grade reading level, incorporating graphics and utilizing alternate format materials for potential members and using a minimum 12-point font or large print (18 point);
(b) MCEs shall ensure that all staff who have contact with potential members are fully informed of MCE and Authority rules applicable to enrollment, disenrollment, complaint and grievance policies and procedures, the availability of free qualified or certified health care interpreters in any language required by the member including American Sign Language, and the process for requesting auxiliary aids or alternative format materials, which participating providers have bilingual capacity, which providers offices/facilities are accessible and have accommodations for people with physical disabilities, including offices, exam rooms, restrooms and equipment and are accepting new members.
(c) MCEs shall make written materials available in alternative formats upon request of the potential member at no cost. Auxiliary aids and services and interpreter services must also be made available upon request of the potential member at no cost.
(d) MCE staff shall be able to provide potential members with information on how to access the Authority Beneficiary Support System, including for dual-eligible members how to receive choice counseling on Medicaid and Medicare options as required in 42 CFR 438.71.

STATUTORY/OTHER AUTHORITY: 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: 414.610 - 414.685

REPEAL: 410-141-3300

RULE TITLE: Managed Care Entity (MCE) Member Education and Information Requirements

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) MCEs may engage in activities for existing members related to outreach, health promotion, and health education. The Authority shall approve prior to distribution any written communication by the MCE or its subcontractors and providers that:

(a) Is intended solely for members; and

(b) Pertains to requirements for obtaining coordinated care services at service area sites or benefits.

(2) MCEs may communicate with providers, caseworkers, community agencies, and other interested parties for informational purposes or to enable care coordination, and address social determinants of health or community health. The intent of these communications should be informational only for building community linkages to impact social determinants of health or member care coordination and not to entice or solicit membership. Communication methodologies may include but are not limited to brochures, pamphlets, newsletters, posters, fliers, websites, health fairs, or sponsorship of health-related events. MCEs shall address health literacy issues by preparing these documents at a low-literacy reading level, incorporating graphics and utilizing alternate formats.

(3) The creation of name recognition because of the MCE's health promotion or education activities may not constitute an attempt by the MCE to influence a client's enrollment.

(4) An MCE or its subcontractor's communications that express participation in or support for an MCE by its founding organizations or its subcontractors may not constitute an attempt to compel or entice a client's enrollment.

(5) The following may not constitute marketing or an attempt by the MCE to influence client enrollment:

(a) Communication to notify dual-eligible members of opportunities to align MCE provided benefits with a Medicare Advantage or Special Needs Plan;

(b) Improving coordination of care;

(c) Communicating with providers serving dual-eligible members about unique care coordination needs; or

(d) Streamlining communications to the dually-enrolled member to improve coordination of benefits.

(6) MCEs shall have a mechanism to help members understand the requirements and benefits of the MCE's integrated and coordinated care plan. The mechanisms developed shall be culturally and linguistically appropriate.

(7) MCEs shall have written procedures, criteria, and an ongoing process of member education and information sharing that includes member orientation, member handbook, and health education. MCEs shall update their educational material as they add coordinated services. Member education shall:

(a) Include information about the coordinated care approach and how to navigate the coordinated health care system, including how to access Exceptional Needs Care Coordination (ENCC) or Intensive Care Coordination (ICC) Services, and where applicable for dual-eligible individuals, the process for coordinating Medicaid and Medicare benefits;

(b) Clearly explain how members may receive assistance from advocates, including certified health care interpreters, community health workers, peer wellness specialists, and personal health navigators, and include information to members that interpreter services in any language required by the member, including American Sign Language, auxiliary aids and alternative format materials at provider offices are free to MCE members as stated in 42 CFR 438.10.

(8) Written member education materials shall:

(a) Ensure written materials, including provider directories, member handbooks, appeal and grievance notices, and all denial and termination notices are made available in the prevalent non-English languages in its particular service area;

(b) Be translated or include taglines in the prevalent non-English languages in the state as well as large print (font size

18) explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the MCE's member/customer service unit;
(c) Be made available in alternative formats upon request of the member at no cost. Auxiliary aids and services must also be made available upon request of the member at no cost.
(9) Electronic versions of member materials, including provider directories, formularies, and handbooks shall be made available prominently on the MCE website in a form that can be electronically retained and printed, available in a machine readable file and format, and readily accessible, e.g., a PDF document posted on the plan website that meets language requirements of this section. For any required member education materials on the MCE website, the member is informed that the information is available in paper form without charge upon request, and the MCE shall provide it upon request within five business days.
(10) MCE provider directories shall include:
(a) The provider's name as well as any group affiliation;
(b) Street address;
(c) Telephone number;
(d) Website URL, as appropriate;
(e) Provider Specialty, as appropriate;
(f) Whether the provider will accept new members;
(g) Information about the provider's cultural and linguistic capabilities including:
(A) Availability of qualified or certified interpreters at no cost to members ensuring oral interpretation is available in all languages and American Sign Language per CFR §438.10;
(B) Availability of auxiliary aids and services for all members with disabilities upon request and at no cost; and
(C) Whether the provider has completed cultural competence training as required by ORS 413.450 and whether providers have verifiable language fluency in non-English (i.e., such as clinical training in a foreign country or clinical language testing);
(D) Whether the provider's office or facility is accessible and has accommodations for people with physical disabilities, including information on accessibility of providers' offices, exam rooms, restrooms, and equipment.
(h) The provider directory must include the information for each of the following provider types covered under the contract, as applicable to the MCE contract:
(A) Physicians, including specialists;
(B) Hospitals;
(C) Pharmacies;
(D) Behavioral health providers; including specifying substance use treatment providers;
(E) Dental providers.
(i) Information included in the provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 30 days after the MCE receives updated provider information. Updated materials shall be available on the MCE website in a readily accessible and machine readable file, e.g., a PDF document posted on the plan website, per form upon request and other alternative format;
(j) Each MCE shall make available in electronic or paper form the following information about its formulary:
(A) Which medications are covered both generic and name brand;
(B) What tier each medication is on.
(11) Within 14 days or a reasonable timeframe of an MCE's receiving notice of a member's enrollment, MCEs shall mail a welcome packet to new members and to members returning to the MCE 12 months or more after previous enrollment. The packet shall include, at a minimum, a welcome letter, a member handbook, and information on how to access a provider directory, including a list of any in-network retail and mail-order pharmacies.
(12) For existing MCE members, an MCE shall notify members annually of the availability of a member handbook and provider directory and how to access those materials. MCEs shall send hard copies upon request within five days.
(13) MCEs shall facilitate materials as follows:

(a) Translate the following written materials into the prevalent non-English languages served by the MCE:
(A) Welcome Packets that include welcome letters and member handbooks; and
(B) Notices of medical benefit changes.
(b) Information on disability access, alternate format and language statement inserts with:
(A) Communications regarding member enrollment; and
(B) Notice of Action Adverse Benefit Determination to deny, reduce, or stop a benefit, and Verification of Services Letter.
(c) Accommodate requests of the member to translate written materials into prevalent non-English languages served by the MCE. Written and spoken language preferences are indicated on the Oregon Health Plan application form and reported to plans in 834 enrollment updates. MCEs shall honor requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested;
(d) Make oral interpretation services available free of charge to each potential member and member. This applies to all non-English languages and American Sign Language, not just prevalent non-English languages.
(14) MCEs must notify enrollees:
(a) That oral interpretation is available free of charge for any language, including American Sign Language, and written information is available in prevalent non-English languages and alternate formats that include but are not limited to audio recording, close-captioned videos, large type (18 font), and braille; and
(b) The process for requesting and accessing interpreters or auxiliary aids and alternative formats, including where appropriate how to contact specific providers responsible through sub-contracts to ensure provision of language and disability access;
(c) Language access services also applies to family members and caregivers with hearing impairments or limited English proficiency who need to understand the member's condition and care.
(15) An MCE shall electronically provide to the Authority for approval each version of the printed welcome packet that includes a welcome letter, member handbook, and information on how to access a provider directory. At a minimum, the member handbook shall contain the following:
(a) Revision date;
(b) Tag lines in English and other prevalent non-English languages, as defined in this rule, spoken by populations of members. The tag lines shall be located at the beginning of the document for the ease of the member and describe how members may access free sign and oral interpreters, as well as translations and materials in other formats. Alternate formats may include but are not limited to readily accessible formatted materials, audio recordings, close-captioned videos, large (18 point) type, and braille;
(c) MCE's office location, mailing address, web address, office hours, and telephone numbers including TTY;
(d) Availability and access to coordinated care services through a patient-centered primary care home or other primary care team with the member as a partner in care management. Explain how to choose a PCP, how to make an appointment, and how to change PCPs, and the MCE's policy on changing PCPs;
(e) How to access information on contracted providers currently accepting new members and any restrictions on the member's freedom of choice among participating providers;
(f) Which participating or non-participating provider services the member may self-refer;
(g) Policies on referrals for specialty care, including prior authorization requirements and how to request a referral;
(h) Explanation of Intensive Care Coordination (ICC) services or Exceptional Needs Care Coordination (ENCC) and how members with the following special health care needs may access these care coordination services: Members who are aged, blind, disabled or who have complex medical needs, high health needs, multiple chronic conditions, mental illness, chemical dependency, or receive additional Authority Medicaid-funded long-term care or long-term services and supports;
(i) Information about the coordinated care approach, how to navigate the coordinated care health care system as applicable to dual-eligible individuals, the process for coordinating Medicaid and Medicare benefits;
(j) How and where members are to access urgent care services and advice, including how to access these services and

advice when away from home;
(k) How and when members are to use emergency services, both locally and when away from home, including examples of emergencies;
(L) Information on contracted hospitals in the member's service area;
(m) Information on post-stabilization care after a member is stabilized in order to maintain, improve, or resolve the member's condition;
(n) Information on the MCE's grievance and appeals processes and the Authority's contested case hearing procedures, including:
(A) Information about assistance in filling out forms and completing the grievance process available from the MCE to the member as outlined in OAR 410-141-3230;
(B) Information about the member's right to continued benefits during the grievance process as provided in OAR 410-141- 3240.
(o) Information on the member's rights and responsibilities, including the availability of the OHP Ombudsman;
(p) Information on charges for non-covered services, and the member's possible responsibility for charges if they go outside of the MCE network for non-emergent care; including information specific to deductibles, copays and coinsurance for dually-enrolled qualified Medicare beneficiaries;
(q) Information about when providers may bill clients for services and what to do if they receive a bill, including information specific to payment responsibilities for dually-enrolled qualified Medicare beneficiaries;
(r) The transitional procedures for new members to obtain prescriptions, supplies, and other necessary items and services in the first month of enrollment if they are unable to meet with a PCP or PCD, other prescribing provider, or obtain new orders during that period; including specific communications for members who are becoming new Medicare enrollees;
(s) Information on advance directive policies including:
(A) Member rights under federal and Oregon law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;
(B) The MCE's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience.
(t) Whether or not the MCE uses provider contracts including alternative payment methodologies or incentives;
(u) The member's right to request and obtain copies of their clinical records, whether they may be charged a reasonable copying fee, and that they may request the record be amended or corrected;
(v) How and when members are to obtain ambulance services;
(w) Resources for help with transportation to appointments with providers and scheduling process for use of non-emergency medical transportation (NEMT) services;
(x) Explanation of the covered and non-covered coordinated care services in sufficient detail to ensure that members understand the benefits to which they are entitled;
(y) How to access in-network retail and mail-order pharmacies;
(z) How members are to obtain prescriptions including information on the process for obtaining non-formulary and over-the-counter drugs;
(aa) The MCE's confidentiality policy;
(bb) How and where members may access any benefits that are available under OHP but are not covered under the MCE's contract, including any cost sharing;
(cc) When and how members may voluntarily and involuntarily disenroll from MCEs and change MCEs;
(dd) MCEs shall, at a minimum, annually review their member handbook for accuracy and update it with new and corrected information to reflect OHP program changes and the MCE's internal changes. If changes affect the member's ability to use services or benefits, the MCE shall offer the updated member handbook to all members;
(ee) The "Oregon Health Plan Client Handbook" is in addition to the MCE's member handbook, and an MCE may not use it to substitute for any component of the MCE's member handbook.

(16) Member health education shall include:
(a) Information on specific health care procedures, instruction in self-management of health care, promotion and maintenance of optimal health care status, patient self-care, and disease and accident prevention. MCE providers or other individuals or programs approved by the MCE may provide health education. MCEs shall make every effort to provide health education in a culturally sensitive and linguistically appropriate manner in order to communicate most effectively with individuals from non-dominant cultures;
(b) Information specifying that MCEs may not prohibit or otherwise restrict a provider acting within the lawful scope of practice from advising or advocating on behalf of a member who is his or her patient for the following:
(A) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
(B) Any information the member needs to decide among all relevant treatment options;
(C) The risks, benefits, and consequences of treatment or non-treatment.
(c) MCEs shall ensure development and maintenance of an individualized health educational plan for members whom their provider has identified as requiring specific educational intervention. The Authority may assist in developing materials that address specifically identified health education problems to the population in need;
(d) Explanation of Intensive Care Coordination (ICC) services or Exceptional Needs Care Coordination (ENCC) and how to access this care coordination through outreach to members with special health care needs including those who are aged, blind, or disabled, or who have complex medical needs or high health care needs, multiple chronic conditions, mental illness, chemical dependency, or receive additional Authority Medicaid-funded long-term care or long-term services and supports;
(e) The appropriate use of the delivery system, including proactive and effective education of members on how to access emergency services and urgent care services appropriately;
(f) MCEs shall provide written notice to affected members of any significant changes in program or service sites that affect the member's ability to access care or services from MCE's participating providers. The MCE shall provide, translated as appropriate, the notice at least 30 days before the effective date of that change, or as soon as possible if the participating provider has not given the MCE sufficient notification to meet the 30-day notice requirement. The Authority shall review and approve the materials within two working days.
(17) Informational materials that MCEs develop for members shall meet the language requirements identified in this rule and be culturally and linguistically sensitive to members with disabilities or reading limitations, including members whose primary language is not English as previously outlined in this rule.
(18) MCEs shall provide an identification card to members unless waived by the Authority that contains simple, readable, and usable information on how to access care in an urgent or emergency situation. The cards are solely for the convenience of the MCE, members, and providers.

STATUTORY/OTHER AUTHORITY: 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: 414.610 - 414.685

REPEAL: 410-141-3320

RULE TITLE: Coordinated Care Organization Member Rights and Responsibilities

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) CCO members shall have the following rights and are entitled to:

(a) Be treated with dignity and respect;

(b) Be treated by participating providers the same as other people seeking health care benefits to which they are entitled and to be encouraged to work with the member's care team, including providers and community resources appropriate to the member's needs;

(c) Choose a Primary Care Provider (PCP) or service site and to change those choices as permitted in the CCO's administrative policies;

(d) Refer oneself directly to behavioral health or family planning services without getting a referral from a PCP or other participating provider;

(e) Have a friend, family member, or advocate present during appointments and other times as needed within clinical guidelines;

(f) Be actively involved in the development of their treatment plan;

(g) Be given information about their condition and covered and non-covered services to allow an informed decision about proposed treatments;

(h) Consent to treatment or refuse services and be told the consequences of that decision, except for court ordered services;

(i) Receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;

(j) Have written materials explained in a manner that is understandable to the member and be educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system;

(k) Receive culturally and linguistically appropriate services and supports in locations as geographically close to where members reside or seek services as possible and choice of providers within the delivery system network that are, if available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations;

(L) Receive oversight, care coordination and transition and planning management from their CCO within the targeted population of the Division to ensure culturally and linguistically appropriate community-based care is provided in a way that serves them in as natural and integrated an environment as possible and that minimizes the use of institutional care;

(m) Receive necessary and reasonable services to diagnose the presenting condition;

(n) Receive integrated person-centered care and services designed to provide choice, independence and dignity and that meet generally accepted standards of practice and are medically appropriate;

(o) Have a consistent and stable relationship with a care team that is responsible for comprehensive care management;

(p) Receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources including but not limited to the use of certified or qualified health care interpreters advocates, community health workers, peer wellness specialists, and personal health navigators who are part of the member's care team to provide cultural and linguistic assistance appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services;

(q) Obtain covered preventive services;

(r) Have access to urgent and emergency services 24 hours a day, seven days a week without prior authorization;
(s) Receive a referral to specialty providers for medically appropriate covered coordinated care services in the manner provided in the CCO's referral policy;
(t) Have a clinical record maintained that documents conditions, services received, and referrals made;
(u) Have access to one's own clinical record, unless restricted by statute;
(v) Transfer of a copy of the clinical record to another provider;
(w) Execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to execute directives and powers of attorney for health care established under ORS 127;
(x) Receive written notices before a denial of, or change in, a benefit or service level is made, unless a notice is not required by federal or state regulations;
(y) Be able to make a complaint or appeal with the CCO and receive a response;
(z) Request a contested case hearing;
(aa) Receive certified or qualified health care interpreter services; and
(bb) Receive a notice of an appointment cancellation in a timely manner;
(cc) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.
(2) CCO members shall have the following responsibilities:
(a) Choose or help with assignment to a PCP or service site;
(b) Treat the CCO, provider, and clinic staff members with respect;
(c) Be on time for appointments made with providers and to call in advance to cancel if unable to keep the appointment or if expected to be late;
(d) Seek periodic health exams and preventive services from the PCP or clinic;
(e) Use the PCP or clinic for diagnostic and other care except in an emergency;
(f) Obtain a referral to a specialist from the PCP or clinic before seeking care from a specialist unless self-referral to the specialist is allowed;
(g) Use urgent and emergency services appropriately and notify the member's PCP or clinic within 72 hours of using emergency services in the manner provided in the CCO's referral policy;
(h) Give accurate information for inclusion in the clinical record;
(i) Help the provider or clinic obtain clinical records from other providers that may include signing an authorization for release of information;
(j) Ask questions about conditions, treatments, and other issues related to care that is not understood;
(k) Use information provided by CCO providers or care teams to make informed decisions about treatment before it is given;
(l) Help in the creation of a treatment plan with the provider;
(m) Follow prescribed agreed upon treatment plans and actively engage in their health care;
(n) Tell the provider that the member's health care is covered under the OHP before services are received and, if requested, show the provider the Division Medical Care Identification form;
(o) Tell the Department or Authority worker of a change of address or phone number;
(p) Tell the Department or Authority worker if the member becomes pregnant and notify the worker of the birth of the member's child;
(q) Tell the Department or Authority worker if any family members move in or out of the household;
(r) Tell the Department or Authority worker if there is any other insurance available;
(s) Pay for non-covered services under the provisions described in OAR 410-120-1200 and 410-120-1280;
(t) Pay the monthly OHP premium on time if so required;
(u) Assist the CCO in pursuing any third-party resources available and reimburse the CCO the amount of benefits it paid for an injury from any recovery received from that injury; and
(v) Bring issues or complaints or grievances to the attention of the CCO.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3340

RULE TITLE: Procedure for General Financial Reporting and for Determining Financial Solvency Matters

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) The Authority shall determine financial solvency of a CCO in accordance with OAR 410-141-3345 through 410-141-3395, the request for applications and the CCO contract. In implementing OAR 410-141-3345 to 410-141-3395, the Authority may enter into a cooperative agreement with another state agency to carry out these provisions. For purposes of obtaining necessary information to determine financial solvency, any reference to OHA in these rules shall include DCBS when DCBS is working cooperatively with OHA to implement these provisions. However, only OHA may take enforcement action or other regulatory sanctions related to the implementation of OAR 410-141-3345 to 410-141-3395 and the CCO contract.

(2) OAR 410-141-3345 to 410-141-3395 are developed in consultation with DCBS in accordance with Section 13, chapter 602, Oregon Laws 2011 (Enrolled House Bill 3650) and Section 1, chapter 8, Oregon Laws 2012 (Enrolled Senate Bill 1580).

(3) Where these rules specify that the OHA may request or receive information or provide a response or take any action, DCBS may act on behalf of OHA. A response to DCBS under these rules shall be considered a response to the OHA on the matter, consistent with the objective of providing a single point of reporting by CCOs.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3345

RULE TITLE: General Financial Reporting and Financial Solvency Matters; CCO Reporting Method

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) Each MCE must demonstrate that it is able to provide coordinated care services efficiently, effectively, and economically. MCEs shall maintain sound financial management procedures, maintain protections against insolvency, and generate periodic financial reports as provided in these rules.

(2) The Authority shall collaborate with the Department of Consumer and Business Services (DCBS) to review MCE financial reports and evaluate financial solvency. MCEs are not required to file financial reports with both the Authority and DCBS except as provided in this section or as outlined in the MCE contract:

(a) Initial applicants for certification as an MCE shall submit all required information to the Authority as part of the application process, and the Authority shall transmit that information to DCBS for its review. In making its determination about the qualifications of the applicant, the Authority shall consult with DCBS about the financial materials and reports submitted with the application;

(b) For purposes of these financial reporting and solvency rules, DCBS is authorized to make recommendations to the Authority and to act in conjunction with the Authority in accordance with these rules. If quarterly reports or other evidence suggest that an MCE's financial solvency is in jeopardy, the Authority shall act as necessary to protect the public interest.

(3) The Authority may address any proper inquiries to any MCE or its officers in relation to the activities or condition of the MCE or any other matter connected with its transactions. The person shall promptly and truthfully reply to the inquiries using the form of communication requested by the Authority. The reply shall be timely, accurate, and complete and, if the Authority requires, verified by an officer of the MCE. A reply is subject to the provisions of ORS 731.260.

(4) MCEs shall follow reporting and documentation requirements found in OAR 410-141-0340 MCE Financial Solvency.

(5) OAR 410-141-3345 through 410-141-3395 provide for three alternative methods for an MCE's solvency plan and financial reporting requirements, depending on the status of the CCO as described in this rule:

(a) The Authority reporting MCE: The CCO complies with restricted reserve and net worth requirements the Authority used to regulate financial solvency of MCEs on July 1, 2012, submitting financial information and reports to the Authority as detailed in the MCE contract. Under this approach, the Authority shall monitor the MCE's financial solvency utilizing the same reporting format and financial standards that the Authority used for MCEs on July 1, 2012;

(b) DCBS reporting MCE: The MCE complies with financial requirements as detailed in the MCE contract and in OAR 410-141-3345 through 410-141-3395, including risk-based capital and NAIC reporting requirements. These requirements shall be monitored by DCBS;

(c) Certificate of Authority: The MCE has a certificate of authority and complies with financial reporting and solvency requirements applicable to licensed health entities pursuant to applicable DCBS requirements under the Oregon insurance code and DCBS rules. In addition, the MCE shall report to the Authority the schedules outlined in the MCE contract.

(6) MCE Status. The method described in this rule that applies to an MCE is determined as follows:

(a) If the MCE is a licensed health entity, the MCE shall use the method described in this rule for certificate of authority. The MCE shall submit a copy of its certificate of authority to the Authority not later than the readiness review document submission date under the initial MCE contract and annually thereafter, not later than August 31. The MCE shall report to the Authority immediately at any time that this certificate of authority is suspended or terminated;

(b) If the MCE is neither a converting MCO nor a licensed health entity, the MCE shall use the method described in this

rule for DCBS reporting MCE;

(c) If the MCE is a converting MCO and is not a licensed health entity, the MCE shall elect either the method described in this rule for the Authority reporting MCE or the method described in this rule for DCBS reporting MCE. The MCE shall notify the Authority of its election no later than the readiness review document submission date under the initial MCE contract. The MCE shall comply with the requirements applicable to its elected method until it notifies the Authority of its intent to change its election. If the MCE expects to change its election, any elements of the solvency plan, or solvency protection arrangements, the MCE shall provide written advance notice to the Authority at least 90-calendar days before the proposed effective date of change. Such changes are subject to written approval from the Authority.

(7) MCE may be required to use specific required reporting forms or items in order to supply information related to financial responsibility, financial solvency, and financial management. The Authority or DCBS, as applicable, shall provide supplemental instructions about the use of these forms.

(8) The standards established in OAR 410-141-3350 through 410-141-3395 are intended to be consistent with and may utilize procedures and standards common to insurers and to DCBS in its administration of financial reporting and solvency requirements. Any reference in these rules to the insurance code or to rules adopted by DCBS under the insurance code may not be deemed to require an MCE to be an insurer but is adopted and incorporated by reference as the Authority standard.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3350

RULE TITLE: Assets, Liabilities, Reserves — DCBS REPORTING CCOs ONLY

NOTICE FILED DATE: 09/13/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) The provisions of this rule apply only to DCBS reporting CCOs, and do not apply to Authority reporting CCOs.

(2) In any determination of the financial condition of a CCO, there shall be allowed as assets only such assets as are owned by the CCO and which consist of:

(a) Cash in the possession or control of the CCO, including the true balance of any deposit in a solvent bank or trust company;

(b) Investments held in accordance with these rules, and due or accrued income items in connection therewith to the extent considered by the Authority to be collectible;

(c) Due premiums, deferred premiums, installment premiums, and written obligations taken for premiums, to the extent allowed by the Authority;

(d) The amount recoverable from a reinsurer if credit for reinsurance may be allowed to the CCO pursuant to OAR 410-141-3380;

(e) Deposits or equities recoverable from any suspended banking institution, to the extent deemed by the Authority to be available for the payment of losses and claims;

(f) Other assets considered by the Authority to be available for the payment of losses and claims, at values determined by the Authority.

(3) In addition to assets impliedly excluded by this rule, the following expressly shall not be allowed as assets in any determination of the financial condition of a CCO:

(a) Advances to officers, employees, agents and other persons on personal security only;

(b) Stock of such CCO owned by it, or any material equity therein or loans secured thereby, or any material proportionate interest in such stock acquired or held through the ownership by such CCO of an interest in another firm, corporation or business unit;

(c) Tangible personal property, except such property as the CCO is otherwise permitted to acquire and retain as an investment under these rules and which is deemed by the Authority to be available for the payment of losses and claims or which is otherwise expressly allowable, in whole or in part, as an asset;

(d) The amount, if any, by which the book value of any investment as carried in the ledger assets of the CCO exceeds the value thereof as determined under these rules.

(4) In any determination of the financial condition of a CCO, liabilities to be charged against its assets shall be calculated in accordance with these rules and shall include:

(a) The amount necessary to pay all of its unpaid losses and claims incurred on or prior to the date of the statement, whether reported or unreported to the CCO, together with the expenses of adjustment or settlement thereof;

(b) For insurance other than specified in Subsection (c) of this section, the amount of reserves equal to the unearned portions of the gross premiums charged on policies in force, calculated in accordance with these rules;

(c) Reserves which place a sound value on its liabilities and which are not less than the reserves according to accepted actuarial standards consistently applied and based on actuarial assumptions relevant to contract provisions;

(d) Taxes, expenses and other obligations due or accrued at the date of the statement;

(e) Any additional reserves for asset valuation contingencies or loss contingencies required by these rules or considered to be necessary by the Authority for the protection of the Authority and the members of the CCO.

(5) If the Authority determines that a CCO's reserves, however calculated or estimated, are inadequate, the Authority

shall require the CCO to maintain reserves in such additional amount as is needed to make them adequate.
(6) Funds of a CCO may be invested in a bond, debenture, note, warrant, certificate or other evidence of indebtedness that are not investment grade as established by these rules, but the funds that a CCO may invest under this section shall not exceed 20 percent of the CCO's assets. For purposes of this rule CCOs shall be subject to the requirements of OAR 836-033-0105 through 836-033-0130.
(7) A CCO shall not have any combination of investments in or secured by the stocks, obligations, and property of one person, corporation or political subdivision in excess of 10 percent of the CCO's assets, nor shall it invest more than 10 percent of its assets in a single parcel of real property or in any other single investment. This subsection does not apply to:
(a) Investments in, or loans upon, the security of the general obligations of a sovereign; or
(b) Investments by a CCO in all real or personal property used exclusively by such CCO to provide health services or in real property used primarily for its home office.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685